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Submissions
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Editorial

Welcome readers. In this issue of the IJIH, we present seven research-based articles that explore some of the health challenges, capacities, and opportunities experienced by Indigenous peoples in Australia, Canada, and New Zealand. Explorations into health challenges such as tuberculosis, substance use, and residential school trauma are grounded in colonial, political, and social contexts, which provide a critical foundation upon which to understand Indigenous health disparities. Similarly, the value and strength of Indigenous approaches, cultures, communities, and families is emphasized in discussions of Indigenous-focused and -led outpatient detox, culture-based healing, traditional foods, and active living interventions.

Sylvia Abonyi and colleagues explored the health experiences of First Nation people living with tuberculosis in Manitoba, Saskatchewan, and Alberta, Canada. Situated within colonial structures and systems, socioeconomic deprivation has resulted in a perpetuation of tuberculosis within many Indigenous communities. Participants of this study discuss the “tipping point” for seeking healthcare and the important influence of family, caregivers, and friends in that process. Jonathan Brett and colleagues assessed the acceptability of Australian Aboriginal community controlled outpatient detox, which was widely supported by participants. In particular, outpatient detox was viewed as a way to ensure individual, family, and community support, which was identified as a key to recovery from alcohol dependence. Tracey Carr and colleagues learned about the perceptions of healing among a group of former Indian residential school students from Saskatchewan, Canada. Although these participants continue to experience negative physical, emotional, mental, and spiritual impacts, many pursue healing through reconnecting with their culture and their faith. Sarah Herbert and colleagues sought to understand the experiences of alcohol use among older Māori people in New Zealand. Within a Māori cultural context, identity, social networks, relationships, and place emerged as important influences of alcohol use across the lifetime. Employing a Kaupapa Māori approach, Glenis Mark and colleagues interviewed rongoā Māori healers to discover the underlying concepts of their practice. Participants described the ways in which Māori beliefs and cultural values are foundational to the concept of rongoā Māori healing. Hannah Tait Neufeld and colleagues sought to understand the knowledge, availability, and use of traditional Indigenous foods among First Nations mothers living in either an urban area or a reserve community in Ontario, Canada. Mothers living in a reserve community reported improved access to traditional foods as well as proximity to the land and traditional food knowledge, while those living in urban areas faced geographic and economic barriers to learning about and accessing traditional foods. Embedded within a Māori philosophy, Anna Rolleston and colleagues engaged Māori participants in a structured lifestyle management programme to assess the impact on their cardiac health. Participants who engaged in this 12-week programme, which included individualized aerobic activities, resistance training, and health education saw significant reduction in weight and cardiovascular disease risk.
On behalf of the IJIH editorial team, we hope readers enjoy and are inspired by these insightful and culturally grounded articles. Thanks once again to all the authors and the Indigenous individuals, communities, and nations with whom they engage in this important work. You make a valuable contribution to our collective goal of enhanced wellness for Indigenous peoples around the globe and in future generations.

In health and healing,

Charlotte Loppie – Editor
“Finally when I started falling down”: Indigenous Tuberculosis Patient Experiences of Health and Illness on the Canadian Prairies

Abstract
This paper adds evidence to a growing body of literature seeking to understand the disproportionate occurrence of tuberculosis (TB) in Indigenous populations of Canada and reveals insights that may inform effective interventions. As a disease, TB is recognized as a disorder of the body, for which there are successful treatments. Its persistence in some populations, however, requires an understanding of TB as an illness, whereby disease is shaped into behaviours and experiences. Fifty-five self-identified Indigenous participants with infectious pulmonary TB completed a questionnaire and an interview as part of the Determinants of Tuberculosis Transmission (DTT) project. Questionnaire data report on sociodemographic information and exposure to TB risk factors, while interview data describe participants’ experiences of TB within the context of their personal histories and everyday lives. Analysis showed that TB symptoms did not stand out as unusual in the everyday life and health experiences of participants. State of health and decisions about accessing healthcare were associated with socioeconomic deprivation, as well as negative experiences connected with historical and contemporary impacts of colonization. The “tipping point” concept effectively captures the shift in health that pushes participants to seek healthcare. Family, friends, and other caregivers are important influences and need to be part of the effort to avoid advanced TB illness and stop the cycle of transmission. More significantly, there is a need to address the structures and systems that produce and perpetuate life conditions that result in a usual state of compromised health.

Keywords
Tuberculosis, Indigenous, Canada, social determinants of health, illness experience, tipping point

Note on Terminology
We use the term Indigenous throughout this paper to refer to the first inhabitants of what is now called Canada. In a global context, this term links peoples in similar circumstances of colonization. Where it appears in the text, the term Aboriginal refers to a formal recognition of Indigenous people in Canada in the Constitution Act of 1982, as members of three groups: First Nations (“Indians”), Métis, and Inuit. Terms used throughout this paper reflect those used in source material. Where we report epidemiological information from our research, we use terms consistent with federal government reporting standards for comparability.
“Finally when I started falling down”: Indigenous Tuberculosis Patient Experiences of Health and Illness on the Canadian Prairies • Sylvia Abonyi, Maria Mayan, Jody Boffa, Carmen Lopez, Kathleen McMullin, Courtney Heffernan, Vernon Hoeppner, Malcolm King, Pamela Orr, Richard Long • DOI:10.18357/ijih112201716900

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Acknowledgements
Thank you to the 55 people who shared their stories with the project team with the hope that their experiences will change for the better the programs, policies, and services that aim to eliminate TB from Indigenous people and communities.

Thanks to Dr. Tatjana Alvadj for her assistance with the literature review, and to Dr. Sara Komarnisky for thoughtful reviews of the text as well as assistance with tables and figures. We appreciate the support of Diana Fedosoff at the University of Saskatchewan and staff at the TB-PERU of the University of Alberta. This research was funded by CIHR (MOP 79373 – Long), Health Canada (HC 4500241519 – Long), and CRC-CFI (201955 – Abonyi).

Thanks also for the contributions of two anonymous reviewers whose insights and suggestions strengthened this work.
Introduction

Tuberculosis (TB) disease variably affects persons worldwide, with Canada having a low national incidence (Public Health Agency of Canada, 2015). TB can affect any organ of the body, though it primarily targets the lungs. Through cough, the bacterium can be transmitted through a process of aerosolization. Disease can occur either imminently or many years after the initial infection. When an infectious state of disease occurs prior to diagnosis, affected individuals may be implicated in increased transmission.

In the Canadian Prairie provinces, TB variously affects Aboriginal people, with incidence rates per 100,000 in 2013 that ranged from 51.1 in Manitoba to 33.1 in Saskatchewan and 6.3 in Alberta. This contrasts with a national incidence of 4.7 in the same year (Public Health Agency of Canada, 2015). Aboriginal people accounted for 90% of Canadian-born adult culture-positive (for Mycobacterium tuberculosis) pulmonary TB cases on the Prairies (Long et al., 2013). Sixty-one percent of these cases were not just culture-positive but also smear-positive, indicating a high degree of infectiousness. Epidemiological analysis has further revealed that, outside of Winnipeg, Manitoba, most cases of pulmonary TB among First Nations and Métis people on the Prairies occurred in a relatively small number of communities north of the 53rd parallel (Long et al., 2013). The inequitable persistence of TB, despite the availability of effective medication, is unacceptable and points to a need for understanding and addressing the drivers that enable TB to persist in Indigenous communities.

This paper draws on data collected in association with the Determinants of Tuberculosis Transmission (DTT) project, an interdisciplinary, multiple-method study grounded in a population-health orientation that began in April 2006. A major objective of the DTT project is to understand the social determinants of TB transmission among the Canadian-born adult population of Alberta, Saskatchewan, and Manitoba with the goal of contributing to the interruption of TB transmission via evidence-informed interventions. A more detailed discussion of the overall DTT project objectives and methodology has been previously published (Boffa, King, McMullin, & Long, 2011). The stories of individuals whose disease progressed to the point of potential infectiousness can reveal important insights about the circumstances that lead to moderate to advanced TB disease and, ultimately, to increased transmission.

Illness and Historical Context

TB Disease Persistence in the Experience of Health and Illness

This paper adds evidence to a growing body of literature that seeks to understand the disproportionate persistence of TB disease in Indigenous populations of the Canadian Prairies and uncover insights that may inform effective interventions. As a disease, TB may be understood as a specific disorder of the body, for which there are effective treatments. Its persistence in some population groups, however, requires an understanding of TB as an illness, which Kleinman (1981) describes as the shaping of disease into behaviours and experiences.
finally when i started falling down": Indigenous Tuberculosis Patient Experiences of Health and Illness on the Canadian Prairies • Sylvia Abonyi, Maria Mayan, Jody Boffa, Carmen Lopez, Kathleen McMullin, Courtney Heffernan, Vernon Hoeppner, Malcolm King, Pamela Orr, Richard Long • DOI:10.18357/ijih112201716900

through personal, social, and cultural reactions to disease. We also drew on Mechanic’s (1982) elaboration of illness behaviour as the way people monitor their bodies (or others’ bodies), define and interpret their symptoms, act, and access care. The basic concepts of illness advanced in these early works hold currency for contemporary TB research (Mason, Degeling, & Denholm, 2015). They lend themselves well to a contemporary population-health orientation that demands attention to the social determinants of health, in considering how disease is shaped into persistent illness through actions and reactions that include, but also move beyond, the personal, social, and cultural to include the political and structural (Møller, 2005, 2010).

Colonization Context

The negative health and social consequences of a long history of colonization, with increasingly aggressive assimilation policies from the end of the 19th century forward, have been extensively described (e.g., Greenwood, de Leeuw, Lindsay, & Reading, 2015; Royal Commission on Aboriginal Peoples, 1996; Waldram, Herring, & Young, 2006). Of significance in this research is residential school policy and mid-20th-century TB treatment in which sanatorium placement was a predominant feature.

While they were established in the 1880s, beginning in 1920 it became mandatory for all First Nations children in Canada aged 7–15 to attend residential schools, where the goal was to assimilate these children into the broader Canadian society (Milloy, 1999). Widespread reports of physical and sexual abuse, poor health with TB identified as an urgent and prevalent issue, and malnutrition have emerged from this era (Bryce, 1922; Milloy, 1999; Mosby, 2013). The last government-run school did not close until 1996. Similarly, from the 1940s to 1960s Aboriginal TB patients were apprehended from their communities to TB sanatoria at some distance from their homes, sometimes for years (Moffatt, Mayan, & Long, 2013). While we touch on its relevance in our Results and Discussion, we have detailed the importance of the sanatorium history for participants in our study elsewhere (Komarnisky, Hackett, Abonyi, Heffernan, & Long, 2016). The disruption to families, communities, and cultures was profound, with the impact of schools recently documented in the summary report of a 5-year national Truth and Reconciliation Commission (Truth and Reconciliation Commission, 2015). Colonization effects, particularly effects of residential schools, are included among the social determinants of health in the population health framework of the Assembly of First Nations that informed this study (AFN, 2006).

Relationships

The DTT project is a patient-based study that followed an extensive engagement and ethical approval process with multiple jurisdictions including Indigenous and non-Indigenous stakeholders. In anticipation of a large number of diagnosed patients in the study period identifying as Indigenous, we followed the Canadian Institutes of Health Research (CIHR) Guidelines for Health Research Involving Aboriginal Peoples, which were the only national...
ethical guidelines in place at the time this study began and which reference the OCAP principles (ownership, control, access, possession)\(^1\) as foundational to the development of research agreements with Aboriginal communities (CIHR, 2013; NAHO, 2005). As a patient-based rather than community-based study, the project was overseen through ongoing consultations with Provincial Network Committees (PNCs), one in each participating province, that were established to guide the study. The PNCs comprised Indigenous Elders, traditional healers, healthcare workers, former patients, and representatives from Aboriginal and governmental stakeholder groups. The process of establishing these committees and acquiring the administrative and ethical approvals is described in detail elsewhere (Boffa et al., 2011). Institutional-level ethics approvals were received from Health Canada and the Prairie province Universities of Alberta, Calgary, Saskatchewan, and Manitoba. In addition to making community visits, a research coordinator in each province participated in local radio interviews to raise awareness of the study.

### Methods

**Healthcare Context**

Potential participants for this study were recruited shortly after their TB diagnosis and as they were navigating treatment and care, which varied according to province of residence and community of residence. In Canada, each province and territory has its own TB prevention and care program, and although they all rely upon the best practices outlined in the Canadian TB Standards (Public Health Agency of Canada & The Lung Association, 2007), they all differ somewhat in how these practices are implemented. For First Nations patients, ancillary services are provided to reserve communities by First Nations Inuit Health either directly or indirectly (e.g., through transferred organizations such as the Northern Intertribal Health Authority in Saskatchewan). Across community types (reserve communities; Métis settlements, or Northern Villages as they are called in Saskatchewan; major metropolitan areas; and non-major metropolitan areas), a wide range of service delivery models were in place at the time of this study. Within Indigenous communities, healthcare provision capacity varied, often based on community size and relative remoteness—from some having a hospital, 24/7 physician coverage, and X-ray facilities, to others having a health centre with a nurse in charge only some of the time and no X-ray facilities.

**Participants and Data Collection**

All adult (> 14 years), Canadian-born, culture-positive pulmonary TB patients diagnosed in a Prairie province between January 1, 2007, and December 31, 2008, and whose contacts were

\(^1\) OCAP\(^\circledast\) is a registered trademark of the First Nations Information Governance Centre (FNIGC; www.fnigc.ca).
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followed until December 31, 2010, were eligible for inclusion in the overall DTT study (N = 248; 223 Indigenous). Out of those eligible, 183 did and 65 did not participate in an oral questionnaire. Of those that did not participate in the questionnaire, 56 were Indigenous (30 were never invited to see a research coordinator about the project, 17 died, and 9 declined). Questionnaire participants who were sputum-smear-positive at diagnosis, indicating a high degree of infectiousness (n = 112; 101 Indigenous), were invited in successive order to participate in an in-depth interview until data saturation was reached. The same research coordinator conducted both the questionnaire and the interview with participants in their respective provinces. Quantitative and qualitative data for each participant were coded with the same case-specific anonymized unique identifier allowing for data linkage. Interviews were conducted with 55 self-identified Indigenous TB patients: 18 in Manitoba, 24 in Saskatchewan, and 13 in Alberta. Figure 1 provides a summary of the eligible population and participants in this study.

Figure 1. Determinants of Tuberculosis Transmission study sample and participants.

As detailed in Table 1, interview participants ranged in age from 17 to 63, with males and females equally represented. Two thirds were First Nations, and one third were Métis. More than three quarters of participants reported fluency in an Indigenous language. Most lived in a rural area with 45% reporting on-reserve residency, while 38% resided in an urban centre.
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Table 1
Interview Participant Sociodemographic Characteristics and Circumstances Associated With Tuberculosis

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total (n = 55)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average age</td>
<td>38</td>
<td>–</td>
</tr>
<tr>
<td>Max. age</td>
<td>63</td>
<td>–</td>
</tr>
<tr>
<td>Min. age</td>
<td>17</td>
<td>–</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>50.9</td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>49.1</td>
</tr>
<tr>
<td>Population group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Nations</td>
<td>37</td>
<td>67.2</td>
</tr>
<tr>
<td>Métis</td>
<td>18</td>
<td>32.8</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/common law</td>
<td>20</td>
<td>36.4</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>9</td>
<td>16.4</td>
</tr>
<tr>
<td>Single</td>
<td>26</td>
<td>47.2</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or further</td>
<td>10</td>
<td>18.2</td>
</tr>
<tr>
<td>No high school diploma</td>
<td>45</td>
<td>81.8</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed at diagnosis</td>
<td>20</td>
<td>36.4</td>
</tr>
<tr>
<td>Not employed at diagnosis</td>
<td>35</td>
<td>63.6</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluent in an Indigenous language</td>
<td>43</td>
<td>78.1</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>21</td>
<td>38.2</td>
</tr>
<tr>
<td>Rural on-reserve</td>
<td>25</td>
<td>45.4</td>
</tr>
<tr>
<td>Rural off-reserve</td>
<td>9</td>
<td>16.4</td>
</tr>
</tbody>
</table>

a Includes residence in a Métis settlement/Northern Village or rural town/village/hamlet.

Participants signed an English-language consent form. Interpreters were available upon request. Caregiver consent was obtained for participants under the age of 18. All interviews included in this analysis were completed in English, audio-recorded, and transcribed verbatim. A semi-structured interview tool was designed to capture participants’ current experience and perceptions of TB, their life history as it relates to the social determinants of health, and their general ideas about health. The interview tool was developed in an iterative review process with members of the PNCs, who also provided guidance on appropriate implementation of the tool. Progress was reported one to two times per year to the PNCs, who provided ongoing guidance during the analysis and interpretation. The findings highlighted in this paper were presented and discussed at PNC meetings, where they were approved for dissemination.

The interview tool consisted of open-ended topics of inquiry (with probes used as appropriate) that included participant life history and home, a typical day before becoming ill, characteristics and conditions of sick and healthy people, participant experience of becoming ill.
with TB, and other illnesses that may be of concern in participant families and communities. This approach allowed participants to discuss whatever they considered important to their TB experience. The PNCs advised the team that this conversational type of approach would be preferable (Kovach, 2009).

The interviews became avenues of exploration for participants who were often, for the first time, trying to make sense of their current TB experience and its impact on their lives. Participants had the opportunity to review their transcribed interviews prior to analysis. One participant requested the opportunity to review and did not return any changes to the original transcript.

Due to differences in the provision of healthcare described earlier, participants were receiving treatment and care for TB in different ways. In Alberta and Manitoba, many were hospitalized at the time of their participation in this study, so they were interviewed there. In Saskatchewan, interviews took place in a variety of locations that included the hospital, patient homes, a hotel, a research space, a correctional facility, and a rural health clinic. A mobile TB clinic allowed patients in Saskatchewan to access virtually all their TB treatment in their home communities. We anticipated that these differences might influence interview responses, so attention was paid to this possibility during analysis. While some differences in the types of frustrations participants expressed about the treatment experience were noted, the overall life experiences they described remained remarkably consistent.

Analysis

Interview transcripts underwent a multistage and iterative coding process among a five-member qualitative sub-team that included the three provincial research coordinators/interviewers and two qualitative co-leads. There was one Indigenous member of this team (co-author KM), who, as a provincial research coordinator, significantly shaped qualitative data collection and analysis. Each member of the coding team individually conducted an initial open coding process. The team met frequently to create a common code list, ensuring that they were sensitive to relevant literature on experiences relating to TB, social determinants of population health, and a First Nations health and determinants framework (AFN, 2006, 2013). The in-person meetings included opportunities for peer debriefing to ensure analytical rigour and to discuss findings. The coding process was managed using ATLAS.ti 5.2.

The open coding process revealed a clear point in each patient story where participants described feeling sick enough to seek healthcare. To understand the context for arriving at this point, we conducted a focused analysis driven by the following questions: What made participants decide “something is wrong with me and I need healthcare”? What were they feeling around that time? What was the “usual health” from which they decided they were unwell enough to seek healthcare? How did they describe a healthy person? The answers to these questions are the focus of this paper. In addition, questionnaire responses for the 55 interviewees were analyzed descriptively to summarize sociodemographic information.
“Finally when I started falling down”: Indigenous Tuberculosis Patient Experiences of Health and Illness on the Canadian Prairies • Sylvia Abonyi, Maria Mayan, Jody Boffa, Carmen Lopez, Kathleen McMullin, Courtney Heffernan, Vernon Hoeppner, Malcolm King, Pamela Orr, Richard Long • DOI:10.18357/ijih112201716900

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Results

In seeking to understand Indigenous patients’ explanations of when they seek healthcare to deal with troubling symptoms, it is important to have some appreciation of their perceptions of good health generally, and of their usual health and circumstances leading up to their current TB illness.

Good Health, Usual Health, and Getting Sick

Overwhelmingly and consistently for all participants, healthy people were described as energetic, engaged, and essentially happy. A Saskatchewan participant described it this way: “If I was healthier my house would be clean every day. I would go to school … I would walk around everywhere. Go visit. I would have a smile on my face every day.” SK001 There were also reflections on the links between health, happiness, stability, and being surrounded by family and friends. A healthy person is “someone that’s happy, like stable in life, has a lot of things happening to keep him or her busy, friends, family.” AB021

These reflections about what an individual in good health looks like were not seen in participant descriptions of their usual state just prior to becoming sick with TB. In their interviews, participants described feeling generally unhappy and inactive. One Saskatchewan participant explained, “I don’t feel like associating with other people and I just want to sleep.” SK001 A Manitoba participant described coughing and weight loss but initially attributed the symptoms to alcohol use: “Started coughing couldn’t stop … quit drinking—still not feeling good, losing weight.” MB012 A third participant described feeling lazy, linking this idea with aging: “But generally, I’ve been for the last couple of years, I guess I’ve been kind of lazy, maybe because I am getting old.” MB014 An Alberta participant reflected,

*I’d wake up, I’d have to always spit up a lot of sputum, and in the morning I ... I just thought it was like either my smoker’s cough or, you know, like just a mild cold that I could get rid of. I’d take either an Advil or Aspirin and keep on going, and yeah, I never suspected it would be TB or something, well, serious enough.* AB021

The responses participants provided to the questionnaire provide further context (Tables 1 and 2). Participants had a low level of educational attainment, with 82% not having completed high school. Over 60% were unemployed. Almost half (47%) reported being single, with another 16% indicating they were either divorced or separated. Thirty-six percent were either married or in a common-law relationship. Many (36%) reported living in crowded housing with perceived poor air quality. About one third of the participants had been incarcerated within the last 2 years. In addition, 38% were already dealing with one or more chronic conditions such as diabetes, HIV infection, or hepatitis C, and many were struggling with substance misuse (alcohol, tobacco, injection drugs, prescription drugs).
Symptoms linked to pulmonary TB include cough (for a period of weeks and possibly with blood), chest pain, loss of appetite, weight loss, fatigue, night sweats, and fever (Long, 2015). Participants did report experiencing many of these symptoms (Table 3).

Analysis of questionnaire responses revealed that almost 93% had a cough, 80% weight loss, and almost 70% night sweats and fever. About 58% indicated other symptoms, which in interviews were captured with phrases such as “takes too long to do something” (Table 3). Several of these symptoms were also associated with their usual state of health, which was far from the ideal health they had also described. Essentially, these were symptoms that would more likely stand out as unusual earlier if participants had been living the life of a healthy person as they described. There was, however, awareness that some of the symptoms they were familiar with in their everyday lives had worsened. As the transition to poorer health was examined further, three interrelated themes were uncovered:
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1. location of TB symptoms in usual day or life events,
2. symptom management to keep going, and
3. fear of being really sick.

The interviews showed that in the weeks and months before their TB diagnosis, one or more TB symptoms were noticeable. One person described his transformation in this way: “Me, I was just skinny and long-haired, and looked terrible, all right!”

### Table 3
**TB Symptoms Described by Participants in Questionnaires and Interviews**

<table>
<thead>
<tr>
<th>Source</th>
<th>TB Symptom</th>
<th>Total (n = 55)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire</td>
<td>Cough</td>
<td>51</td>
<td>92.7</td>
</tr>
<tr>
<td></td>
<td>Fever</td>
<td>38</td>
<td>69.1</td>
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<tr>
<td></td>
<td>Night sweats</td>
<td>37</td>
<td>67.3</td>
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<tr>
<td></td>
<td>Weight loss</td>
<td>44</td>
<td>80.0</td>
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<tr>
<td></td>
<td>Fatigue</td>
<td>16</td>
<td>29.1</td>
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<tr>
<td></td>
<td>Chest pain</td>
<td>9</td>
<td>16.4</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>32</td>
<td>58.2</td>
</tr>
<tr>
<td>Interview</td>
<td>Sleepy</td>
<td></td>
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<tr>
<td></td>
<td>Takes too long to do something</td>
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<tr>
<td></td>
<td>Sore ribs, chest pain</td>
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<tr>
<td></td>
<td>Bones were sore, muscles were sore, back sore</td>
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<td></td>
<td>Get really tired, really fast</td>
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<tr>
<td></td>
<td>Nose was stuffy, congested</td>
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<tr>
<td></td>
<td>Heartburn</td>
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<td>Couldn’t breathe</td>
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Participants linked experiences of their usual day or life events to explanations for the symptoms. Fatigue, for example, was linked with general unhappiness. In many of the interviews unhappiness related to a recent personal loss, such as a relationship, or death of a friend or relative. Coughing and smoking were associated in many stories. Participants struggling with substance use linked their weight loss or lack of appetite to this issue. The words participants used to describe their feelings around the time they began to feel really sick (Table 3) were also reflections of their usual day, but were escalating to interrupting that day. The theme of symptom management emerges at this point. As participants went on to describe worsening symptoms, many sought to manage them either by sleeping or by medicating in some way. The narrative given by the following participant covered a winter season during which three major TB symptoms—fatigue, coughing, and weight loss—were experienced as worsening. Of significance
is that this participant’s story, as did some others, included multiple contacts with health professionals:

And I started coughing lots. I couldn’t, I can’t walk long ways. I get tired really fast so I figure it’s just the flu, you know, and then it just went on and on and that ... then I started taking these, uh, seeing doctors about painkillers. I started taking Tylenol 3s [acetaminophen with codeine] ... That kept me going. I lived with this thing all winter like that … I was boarding with my sisters … I slept lots. I didn’t even eat very much. I smoked a lot of cigarettes.  \(^{AB006}\)

For a time, participants could “keep going” with behavioural coping strategies, such as sleeping, or taking cold and pain medication. The third theme, fear of being really sick, also drove participants to symptom management to keep going, even when there was finally the recognition that they were really unwell, that their condition was serious. Participants expressed a constellation of fears. Women, some of whom were single parents, were reluctant to even visit the nursing station down the road in their remote communities, because they were primary caregivers for children or others and were not sure who could care for them even for a short absence. Some were afraid of losing their jobs, especially in workplace environments hostile to Indigenous workers. One man stated:

\(I want to keep working, because Aboriginals were getting fired there and I, if I’m going to call in sick, (they’ll) think that it’s just from drinking. I started brainwashing myself like that, you know. I don’t want to go home, I’m not that sick, so I just kept going to work like that.\)  \(^{AB040}\)

Others were afraid of being diagnosed with an infectious illness, recalling or being told stories of what happened to these individuals in the past:

\(I’ve heard of this where, where you have a hospital in ____ where I knew this one Inuit guy that was stuck there for about three years. It took him over three years. He told me that. He says, “If they take, they take you and throw you in there, you won’t get out [of] there.”\)  \(^{AB018}\)

**Falling Down**

Many participants described arriving at a point in their illness experience when they were no longer able to get through a day of usual tasks, even with the strategies they had implemented to manage symptoms. At this point, participants described literally falling down, and being left with no other choice:
“Finally when I started falling down”: Indigenous Tuberculosis Patient Experiences of Health and Illness on the Canadian Prairies • Sylvia Abonyi, Maria Mayan, Jody Boffa, Carmen Lopez, Kathleen McMullin, Courtney Heffernan, Vernon Hoeppner, Malcolm King, Pamela Orr, Richard Long • DOI:10.18357/ijih112201716900

I even knew I had to come to hospital, but I just couldn’t face myself that I had to. And finally, finally, when I started falling down I, I had no choice then.”

Friends, family, and others played an important role in convincing participants to see a health professional. The mother of one young man noticed her son falling asleep through the day. It was the brother of another participant who noticed his weight loss, telling him he looked sick. A young woman’s friends teased her that she had lost so much weight that she would blow away when she went outside. Nephews and nieces told one Auntie that she “might even have the disease” (referring to HIV). One participant noted that a family member told her, “Sometimes you look like it is not you.” At this point, she said, “That day they talked me into going to … hospital.”

Discussion

TB Symptoms Experienced in Context

Interviews with TB patients revealed some explanations for the advanced state of TB disease. Participants’ descriptions of healthy people were not characteristic of their own lives in the weeks and months leading up to their diagnosis. Symptoms that in healthier individuals would stand out sooner as something new were initially interpreted as the worsening of a usual state of health associated with influences such as smoking or substance misuse. Participants also discussed recent personal losses in the form of relationships or deaths. Sleeping, withdrawal from community participation, and substance misuse were some mechanisms participants used for coping with challenges and symptoms.

Embedded in the life histories participants described, the recognition of symptoms as unusual and alarming can clearly be delayed. It is important to recognize that TB symptoms are non-specific and do not present all at once, and like other slowly progressive diseases, symptoms are universally recognized later in the disease course by patients and healthcare providers (Bastin et. al., 2010; Long, 2015; Ward, Marciniuk, Pahwa, & Hoeppner, 2004). The finding that TB symptoms were initially associated with other explanations, including other illnesses such as colds and flu, has been reported elsewhere (Auer, Sarol, Tanner, & Weiss, 2000; Jaramillo, 1998; Liefooghe, Baliddawa, Kipruto, Vermeire, & De Muynck, 1997; Mann Woith & Larson, 2008; Nnoaham, Pool, Bothamley, & Grant, 2006). Participants’ stories also captured experiences consistent with a systematic review that identified delay in the diagnosis and treatment of TB because of the coexistence of chronic cough, rural residence, low healthcare access (geographic or sociopsychological), poverty, substance use, symptom management, and stigma (Storla, Yimer, & Bjune, 2008). Even at the point that participants realized they were quite unwell and accessed healthcare, they received treatment for symptom management (e.g., Tylenol 3), suggesting their symptoms were not associated by their providers with TB. In addition, fears associated with caregiving responsibilities and job loss resulted in some participants attempting
to manage symptoms (sleep, painkillers) for as long as possible to just keep going. Turris (2009) similarly found that for women seeking care for possible symptoms of cardiac illness, decisions about treatment seeking were influenced primarily by the contexts of their lives as mothers, daughters, and wives and only secondarily by their symptoms. Many of these explanations are in contemporary experiences of the social determinants of health, including access to healthcare, which the Assembly of First Nations population health framework (AFN, 2006, 2013), links to determinants of historical significance.

Stories shared by Indigenous participants in this research certainly point further upstream from their life circumstances today to the effects of historical colonization and colonialism. Møller (2005, 2010) explains that while there may be cultural differences in the way that Aboriginal Peoples and Western healthcare view body, health, and disease, these differences are less important than the effects of colonization and colonialism in the way that TB is experienced and given meaning, and care is accessed. Some participants in our study expressed general feelings of hopelessness and despair about their TB experience in the context of their lives. In a related analysis, we contextualized these expressions through a Cree fictional character called Old Keyam, who embodied the struggles of Indigenous people within colonization policies (McMullin et al., 2012).

The colonization of Indigenous people, including residential schools, and the intergenerational trauma connected to this, has resulted in collective contemporary challenges to well-being (Aguiar & Halseth, 2015) and to the state of healthiness that participants described as “happy, stable, busy.” As we have elaborated elsewhere for participants in this study (Komarnisky et al., 2016), and as Møller (2005, 2010) has described for the Inuit, related studies among contemporary Alberta TB patients also point to the legacy of the TB sanatorium era as contributing to delays in seeking diagnosis and treatment, and a general apprehension about healthcare (Gibson, Cave, Doering, Ortiz, & Harms, 2005; Moffatt et al., 2013). Research in urban Montreal reported similar findings on the impact of negative memories and experiences rooted in colonial treatment strategies as being significant for the mistrust Indigenous participants expressed towards the contemporary healthcare system (Brassard, Anderson, Menzies, Schwartzman, & Macdonald, 2008; Macdonald, Rigillo, & Brassard, 2010). Elliott and de Leeuw (2009) reported misunderstandings in encounters between family doctors and Aboriginal patients that also highlight the relevance of sanatorium history as well as the impact of contemporary negative images of “drunken Indians” that stereotype and pathologize Aboriginal people. These observations are not new (O’Neil, 1989) and continue to be widely experienced (Allan & Smylie, 2015; Jacklin et al., 2017).

The consequence of all of this, as we have seen in this study, is that participants describe a point in their illness experience when they are literally falling down. In addition, friends and family members who also notice their physical deterioration play an important role in pushing them to pursue healthcare access. Early symptom recognition in association with TB is clearly important for preventing serious disease and interrupting transmission. It is well established that
the longer the duration of symptoms in the source case, especially if that source case is smear-positive, the greater the risk of transmission (Lohmann et al., 2012). Health Canada (2012) reported that, in First Nations reserves in Canada, symptomology is the most common method of case detection (57.3% of cases). Between 2000 and 2008, 64.6% of on-reserve cases in Alberta, 59.8% of cases in Saskatchewan, and 53.5% of cases in Manitoba were detected in this way (Health Canada, 2012, Table 4).

“Tipping Point”

A concept originating in physics, the tipping point simply refers to the notion of adding a small amount of weight to a balanced object until it topples over. Sociologist Morton Grodzins (1957, 1958) and economist Thomas Schelling (1969, 1971, 1978) adapted the concept as a powerful metaphor for human group behaviour, in their case specific to neighbourhood racial segregation. The concept has since been subject to further scholarly consideration (e.g., Clark & Fossett, 2008; Zhang, 2004) and popularized (Gladwell, 2000), and the term “tipping point” has become common in the English lexicon.

We find the metaphor similarly powerful for interpreting the moment patients recognize their symptoms as unusual. The tipping point effectively captures the cumulative small actions, incidents, and experiences patients describe that tip the balance of symptoms being associated with usual health to being exposed as a new or more severe illness. The moment of recognition that participants in this study experienced caused them to seek healthcare, or for those who had already done so, to persist, often with the support of friends or family. Of significance to our analysis is that the tipping point for the participants in this study was simply too late. Explanations for the late arrival to a tipping point for Indigenous participants are in a common context that includes colonization and its influences on their contemporary experience of social determinants of health (AFN, 2006, 2013). This leads them as a group to experience poorer overall usual health than non-Indigenous people in Canada and, as highlighted earlier in the Discussion, potentially avoid accessing healthcare. Tipping points need to be shifted back to identify illness well before Indigenous people afflicted with TB become so sick that they fall down, and to reduce the spread of TB disease among Indigenous people and communities on the Canadian Prairies.

Many of the participants in this study were from communities where the occurrence of TB is not unusual (Long et al., 2013). At the same time healthcare worker vacancies in these communities are not uncommon and continuity of care is typically lacking. Although there are some Indigenous healthcare workers, there are not nearly enough. Education about TB, how it presents, its relationships to other illnesses (e.g., HIV/AIDS), stigma, cultural competency, and patient safety represent pressing needs, especially in high-incidence communities. Orr (2011a, b) identified these and other issues in a two-part systematic review of adherence to tuberculosis care in Canadian Aboriginal populations. While the focus of these reviews was on adherence to treatment, these same findings are also relevant to moving back the tipping point for TB.
symptom recognition. In her reviews, Orr (2011a, b) points to the responsibility of healthcare personnel and the system to build quality relationships with Aboriginal people and communities, and to create TB programs that consider the complex interactions between health systems, societal factors, and personal factors. As this study shows, these influence tipping points and access to healthcare. Finally, Orr (2011b) also explains that TB programs should have meaning consistent with Indigenous beliefs about causation and care. Citing his vivid recollection of a story of the achievement of wellness shared by an Indigenous community member co-infected with TB and HIV, one co-author (MK) has suggested that late biomedical treatment-seeking behaviours may be linked to what his research on wellness has revealed as a capacity to achieve wellness outside biomedical intervention (Macklin, Beaudoin, Lu, King, & King, 2014).

These complexities are consistent with Waisbord’s (2007) argument that TB communication programs should adopt a “social rationality” perspective that draws on nuanced understandings of community TB experiences. These understandings may draw on systemic deficits as well as capacities outside Western healthcare. It is important that the latter is not simplistically interpreted as blaming the individual for delayed recognition of symptoms as possible TB, or delayed access to biomedical healthcare. In addition to the responsibilities of healthcare workers and the health system, strategies to link symptoms to possible TB earlier must include family and friends, since they are often the first to notice changes (e.g., more coughing, more sleeping, weight loss). Furthermore, they play a key role in supporting sick individuals to seek healthcare.

Finally, these ideas are very much centred on working within the status quo life experience of the Indigenous people who shared their TB experiences with us. Truly moving back the tipping point will require recognition that the “usual” experience of health from which symptoms of illness are interpreted should more closely align with the aspirations for good health participants identified. For Indigenous Peoples, this requires action on the contemporary social determinants of health, and on the intergenerational legacy of colonization (Greenwood et al., 2015; Reading & Halseth, 2013). Ideally, this would follow a population-specific framework, such as that produced by the Assembly of First Nations (AFN, 2006, 2013), which pays explicit attention to determinants such as colonization and self-determination that are not included elsewhere, such as the determinants that guide public health policy in Canada (Public Health Agency of Canada, 2013).

Limitations and Conclusions

Effectively interrupting TB transmission involves several people (the TB-infected individual, those with close relationships to that individual, and healthcare providers), and multiple tipping points, all of which need to be moved back. This study provides some understanding for the first of these—the tipping point for Indigenous TB patients on the Canadian Prairies.
This narrative is important and should be privileged as it was here. Patient and community voices are too often absent in the consideration of policy and program interventions. The stories in this study show that patients were spending time with friends and family. In addition, there were contacts with healthcare professionals and with the healthcare system in the weeks or months prior to a TB diagnosis, as they received prescriptions to manage various symptoms.

Moreover, though we have not addressed it in this paper, the interviews revealed that the tipping point for participants did not always translate into a timely diagnosis of TB. We did not conduct interviews with family members of TB patients or with healthcare providers who would have allowed us to probe this fully. These are avenues for future research that would provide further insight into the tipping points for all involved in achieving an earlier TB diagnosis.

Finally, there is a need to look at the structures and systems that produce and perpetuate inequitable distribution of the conditions that produce population-level disparities in the circumstances of usual health.

References
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Healing at Home: Developing a Model for Ambulatory Alcohol “Detox” in an Aboriginal Community Controlled Health Service

Abstract

Introduction: Indigenous Peoples who have been colonized face a higher burden of harm from alcohol and increased risk of alcohol use disorders. Yet they often also have limited access to alcohol treatment. Limited access to withdrawal management (“detox” in particular) can be a barrier to recovery. Ambulatory or “outpatient” alcohol detox can offer improved treatment access, but no research has examined its feasibility and acceptability in Indigenous populations.

Aim: To develop a model for outpatient detox delivered by an Australian Aboriginal community controlled health service (ACCHS), and to describe its feasibility and acceptability. Methods: This report describes a framework for alcohol treatment service development within an ACCHS through community, staff, and client consultation. Thematic analysis of focus groups and phone interviews were used to gain insight into the views and experiences of Aboriginal community stakeholders, service clients, and staff regarding alcohol detox services and the pilot of the outpatient detox program service model. Results: Individual, family, and community support was regarded as key to recovery from alcohol dependence. Outpatient detox was seen as a way of keeping the individual near this support. Reported positive aspects include satisfaction with the approach to care that was considered accessible, holistic, and integrated. Challenges and suggested improvements were identified. Discussion: Outpatient detox within an ACCHS was assessed as feasible and acceptable for carefully selected clients and was reported to aid access to treatment. More clinical experience is needed to fully delineate effectiveness and safety.

Keywords
Aboriginal, Australians, alcohol, withdrawal, outpatient, home, detox

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Introduction
Indigenous Peoples who have been colonized typically face a greater burden of injury, disease, and social disruption associated with alcohol use (Kirmayer, Brass, & Tait, 2000). However, they often also encounter many barriers to accessing treatment for alcohol use disorders (Gray, Stearne, Wilson, & Doyle, 2010). Aboriginal and Torres Strait Islander Australians (here described as Aboriginal Australians) experience 3–8 times the prevalence of alcohol-related illness, injury, and death than the general population (Calabria, Doran, Vos, Shakeshaft, & Hall, 2010). But their barriers to treatment access for alcohol dependence include transport difficulties, fear of discrimination, and lack of culturally secure services (Brett et al., 2016; Conigrave et al., 2012; Gray, Stearne, et al., 2010; Teasdale et al., 2008).

Ensuring prompt access to quality, evidence-based, and appropriate health care for Aboriginal people with alcohol use disorders is a priority (Gray, Saggers, Wilkes, Allsop, & Ober, 2010). This requires Aboriginal expertise in service development, delivery, and evaluation (Lee et al., 2014).

Alcohol withdrawal management (“detox”) can be an essential step on the path to recovery from alcohol dependence. Untreated severe alcohol withdrawal can result in seizures and delirium tremens, while in untreated moderate alcohol withdrawal the experience of insomnia, anxiety, and intense craving can lead to a return to drinking (Saunders et al., 2016). Furthermore, those drinkers who need residential rehabilitation (“rehab”) are typically asked to complete alcohol withdrawal before they can enter a rehab unit.

Medical management of alcohol withdrawal typically involves supplying a reducing dose of a long-acting benzodiazepine (typically diazepam) under health professional supervision. Thiamine (and sometimes other vitamins) is also supplied, along with psychological support and recovery planning. The diazepam treatment reduces the risk of serious complications such as seizures or delirium tremens and increases the likelihood of successful completion of withdrawal.
In Australia, most rehabs do not have detox services on site, and the difficulty of finding a bed first in a detox and then in a rehab can be both daunting and time consuming. Residential or inpatient alcohol detox settings have limited space and often long waiting lists (Gray, Stearne, et al., 2010). This often results in missed opportunities for motivated individuals to engage with treatment.

In general populations, outpatient detox can be safe and cost-effective for carefully selected individuals (Haber, Lintzeris, Proude, & Lopatko, 2009). Accordingly, outpatient detox is part of the Australian alcohol treatment guidelines (Cusack & de Crespigny, 2007; Haber et al., 2009). Models have typically included daily clinic or (occasionally) home visits (Blondell, 2005; Brett, Lawrence, Ivers, & Conigrave, 2014; Carlebach, Wake, & Hamilton, 2011). However, there is limited understanding of the Aboriginal community’s preferences for detox (Conigrave et al., 2012), and there are no studies detailing how a culturally appropriate model of care could be established and evaluated.

Anecdotally, a small number of Aboriginal community controlled health services (ACCHSs) have provided outpatient detox on an ad hoc basis (Brett et al., 2014). ACCHSs can reduce barriers to health care and improve health outcomes for Aboriginal people (Panaretto, Wenitong, Button, & Ring, 2014). Establishing a model of outpatient detox within an ACCHS could potentially offer accessible, culturally secure, and community-prioritized health care (Gray, Stearne, et al., 2010).

Illawarra Aboriginal Medical Service (IAMS), an ACCHS in a regional town of New South Wales (NSW), Australia, had experienced difficulty accessing residential detox for clients with alcohol dependence and set out to develop and evaluate a model for outpatient detox. The objectives of this program were (a) to improve access to treatment for alcohol dependence, (b) to improve client engagement, (c) to medically manage alcohol withdrawal in a culturally safe environment, and (d) to facilitate ongoing recovery.

To develop this program, staff of the ACCHS (LL, RI) established partnerships with researchers and addiction medicine specialists (AD, JB, KC) in a nearby urban centre. These academics sourced funding for program development and evaluation through a not-for-profit organization, the Foundation for Alcohol Research and Education. The authors first reviewed mainstream literature, then consulted with other services which had sporadically provided outpatient detox to Aboriginal Australians (Brett et al., 2014).

The current report describes the results of qualitative research that informed program development, the model of outpatient detox that was adopted, and the early evaluation of program feasibility and acceptability.

**Methods**

A descriptive qualitative study was undertaken to explore perceptions and experiences of alcohol detox during the planning and early implementation of a pilot model of outpatient home detox in IAMS, an ACCHS in regional NSW, Australia. We aimed to understand community
knowledge and shared meaning regarding approaches to alcohol detox, as well as early client and staff experiences of the program.

We conducted interviews and focus group discussions with community members, interviews with early clients of the program, and consultations with clinic staff between October 2013 and October 2014.

The knowledge and perceptions of alcohol detox held by Aboriginal community members and ACCHS staff were explored. This qualitative information was used together with data from the previous literature review and health service consultation (Brett et al., 2014) to design a model of outpatient detox.

After the pilot program was implemented, early feedback on feasibility and acceptability was collected from clients and service providers. This was done via a client satisfaction survey, phone interviews of clients, and face-to-face interviews of service staff.

Ethical approval for this study was obtained from the Sydney Local Health District Human Research Ethics Committee and the Ethics Committee of the Aboriginal Health and Medical Research Council, NSW.

Interviews and Focus Groups

**Participant selection and recruitment.** Purposive criterion selection was employed to investigate in-depth cases (community leaders, clients, and staff of the project) to identify the variety of contextual and service factors that make up effective alcohol detox in this one Aboriginal community. In designing the program, local Aboriginal community stakeholders were identified by ACCHS staff and invited to participate in a focus group at the ACCHS. Additional in-depth personal perspectives were gained through one-on-one telephone interviews.

After implementation of the pilot program, the first eight clients who commenced treatment with the program were approached to participate in phone interviews. Phone interviews seemed to be the mode preferable to participants and were thought likely to optimise participation. On conclusion of their detox each client was asked by staff to complete an anonymous satisfaction survey.

Investigators also invited key staff working within the program to participate in a group consultation and face-to-face individual interviews.

**Data collection.** An experienced independent Aboriginal facilitator led the community stakeholder focus group. An independent non-Aboriginal interviewer (Christopher Ganora, CG) also subsequently conducted individual telephone interviews with the same participants to allow participants further opportunity to express individual opinions and clarify certain points. The same interviewer (CG) also conducted client interviews. The investigators (JB, KC) conducted group and also private individual staff consultations.

The focus group and interviews were loosely structured. Questions were formed in consultation with Aboriginal clinic staff. Areas explored included understandings of alcohol detox; experience with and views on outpatient detox; and issues associated with access to such a
service, including acceptability and cultural appropriateness, and how access barriers could be reduced. If participants had limited knowledge of the subject, prompts were given to help stimulate recall of relevant personal experience or knowledge.

Client interviews included questions to explore pre-existing knowledge about detox, their perception of accessibility of the program, adequacy and appropriateness of information provided, satisfaction with the program, integration of aftercare, and suggestions for improvement. Staff consultation sought to determine satisfaction with program processes and outcomes.

The client satisfaction survey used a Likert scale and was completed by pen and paper.

**Data analysis.** The focus group and telephone interviews were recorded and transcribed verbatim. Two researchers (JB, AD) thematically analyzed the transcripts. They familiarized themselves with the transcripts and coded them independently. JB and AD met several times to discuss emergent categories and agree upon themes. Written notes were taken during and immediately after staff consultation, then typed and thematically analysed by two researchers (JB, KC). ACCHS staff and the facilitator/interviewer checked themes to ensure findings were factually correct, culturally safe, and respectful.

**Results**

Eight stakeholders (identified as SH1 to 8), comprising four local community Elders and four Aboriginal community members employed in government services, consented to participate in the study prior to program development.

After the pilot program had been developed and implemented, four of the eight clients who completed the program (CL1 to 4) consented to interviews, while four declined. Due to the small size of the community, further participant characteristics are not revealed to preserve anonymity. Seven program staff participated in consultations: one general practitioner (GP), one GP trainee, two practice nurses, and three Aboriginal drug and alcohol workers.

The themes that emerged from interviews and focus groups are described below.

**Interviews and Focus Groups to Inform Model of Service Delivery**

**Lived experience of nature and effects of alcohol misuse.** All community stakeholder participants had personal or professional experience of alcohol misuse and related consequences, and all acknowledged that alcohol was a problem within the local Aboriginal community. The intergenerational nature of alcohol misuse, trauma, and disempowerment was described.

**Resilience.** Despite the difficulties of their personal experiences, participants expressed their ability to adapt to stress and adversity. Resilience was expressed through participant descriptions of needing to remain strong and to keep the family together. There was generally a feeling of hope for the future, and all stakeholders expressed the need to be proactive in dealing
with alcohol problems: “Shake your eyebrows and let all that dust, all that grit fall off you. Then you can see a beauty that surrounds you when you don’t have alcohol” (SH8).

Understanding of detox and service needs. There was a general understanding that withdrawing from alcohol could be difficult: “When detoxing it can become a rough thing” (SH3). A few of the community stakeholders had personal experience of alcohol withdrawal. However, only one identified the need for medical withdrawal management. “They can’t go cold turkey with it straight away because it might have other health effects” (SH1).

Several participants described alcohol withdrawal in the literal sense of “detoxification,” a feeling that the body was contaminated with toxins that needed to be purged. “If you can get in there early enough you can clean them out … it means cleaning your body of all those dreadful things that come from alcohol” (SH2). A minority of community stakeholders understood the process of medical management of alcohol withdrawal as involving medication with benzodiazepines and regular monitoring.

One participant identified the lack of options for detox as a barrier to entering rehabilitation. However, there was a general confusion between detox and rehab, with most participants thinking that the two were synonymous.

The theme of the drinker needing to be isolated in order to treat alcohol “problems” emerged during several interviews: “They locked them away until they come home, fully clean of alcohol” (SH7).

All stakeholders identified the need for more and improved local alcohol treatment services. This included a need for services to deal with complex needs, such as psychiatric co-morbidity.

Motivation. Engagement and remaining motivated were considered central issues in treatment. Motivation was perceived at the level of the individual, the family, and the community. Furthermore, recovery was often expressed as a journey: “That’s a journey the family can take together” (SH1).

Views on acceptability; defining the model. Participants expressed a range of views on what they felt would constitute an acceptable outpatient alcohol detox service (Table 1):

Cultural safety. Trust was seen as a major factor for most people in terms of who provided the service: “Let them put their trust in you first” (SH6). There was a feeling that with the right services, support, and commitment, outpatient detox was acceptable. “It’s culturally comfortable for them to be there if they have the right support through services who may assist them on a daily or weekly basis to commit to their journey” (SH3).

Shame and privacy. Shame was seen as a barrier to help seeking, in particular in group treatment environments. What is more, group settings could lead to leakage of personal information to the wider Aboriginal community. “If someone wants to detox, they can do it from
home. I’m sure that a lot of people would put their hand up rather than … to have to face their demons and be brought out, like shunned or put up on the limelight in the community and say that this person has an issue around alcohol” (SH3).

**Issues with mainstream services/preference for Aboriginal controlled services.** Both community stakeholders and clients felt that some Aboriginal people would prefer an Aboriginal specific service: “I know a lot wouldn’t go to the mainstream one, they would only go to the Indigenous one” (SH4). Some of them also related negative personal experiences within mainstream services: “They just don’t like the hospital thing because they think … nurses and everyone doing wrong by them” (SH7). Therefore, providing outpatient detox through an ACCHS was generally seen as preferable.

**Keeping the family together.** Being able to keep the family together through treatment, to understand the family context, and even to engage the family during detox and beyond was an emergent theme. This also related to family commitment as an important motivator. It was appreciated that these family-focused goals could be achieved with an outpatient withdrawal program. “They want to be close to their families for support, so they can talk to them and be there for them. It’s just too difficult when they know they’ve got to travel a couple of hundred kilometres away. They just give up” (SH1).

**Focusing on community for recovery.** Reconnecting with community to share experiences and information was seen as an important motivator and identified as a priority to integrate into the program. Stakeholders talked about the importance of accessing men’s and women’s groups through the program as a way to achieve this and to prevent alcohol harms in others.

The need for individuals within the community to serve as champions to promote new services such as this program was described: “They’ve got to get the right information to the right people that want to do the detox” (SH1).

A community need for services such as the program to engage and assist Aboriginal youth drinkers was also expressed: “Get through to the kids and say ‘Do you want to end up like that?’” (SH2).

**Accessible and streamlined.** One of the issues expressed by ACCHS staff prior to the opening of the program was that existing detox services were difficult to access because of the number of assessments clients have to go through. These assessments could occur over several days, resulting in a high client attrition rate.

Transport was seen as a major barrier to accessing care at other mainstream services: “Transport is another difficulty … a lot of them don’t have cars” (SH4).

**Commitment and planning for the future.** Commitment of the program staff to the clients was seen as essential. “If you’re going to make it a home detox, you just need to keep …
on top of it, a constant check-in to keep them motivated and focused on what they’re achieving” (SH3).

All participants felt that the journey did not end following detox and that ongoing commitment from all involved was important: “It doesn’t just end when they’re in there; they’ve got to have that follow-on when they leave” (SH6).

The need for relapse prevention approaches even during the detox process was described by community stakeholders.

**Peer support and champions for the program.** The importance of positive early community experience of the program for its ongoing success was voiced. The concepts of peer support and role models were raised, in which individuals who had successfully completed the program could promote it or support their peers through the process: “You just need one or two people to give the program [a try] for it to be successful and they’ll probably carry the flag for you” (SH1).

**Table 1**

<table>
<thead>
<tr>
<th>Desired Characteristics</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cultural safety</td>
<td>• Other drinkers may be nearby</td>
</tr>
<tr>
<td>• Privacy / avoid shame</td>
<td>• Boredom and all the usual triggers to relapse may be present</td>
</tr>
<tr>
<td>• Preference for Aboriginal controlled services</td>
<td>• A new service will take time to engender trust</td>
</tr>
<tr>
<td>• Keep family together</td>
<td></td>
</tr>
<tr>
<td>• Focusing on community for recovery</td>
<td></td>
</tr>
<tr>
<td>• Accessible and streamlined</td>
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<tr>
<td>• Commitment to clients and planning for the future</td>
<td></td>
</tr>
<tr>
<td>• Peer support and champions for the program</td>
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</tbody>
</table>

**Anticipated Challenges**

Participants anticipated several challenges to the outpatient withdrawal program (Table 1). Having other drinkers in the home environment was a common theme: “If someone else walks into the house with a bottle in their hands, that’s when they could fall back” (SH4). Some of the participants expressed a concern that drinkers could be exposed to all of the triggers to drink in their usual environment: “It’s a comfortable environment for them. It’s so easy for them to just slip back into their habits” (SH3). Several community stakeholders felt that if people are
isolated in their own homes, then boredom and difficulty coping with cravings due to the lack of distractions may lead to relapse.

One participant felt that people may take some time to trust and engage with a new service: “A lot of black fellas, they’re always unsure of the unknown” (SH1).

The Development of a Model for Outpatient Detox

Existing scientific literature (Blondell, 2005; Carlebach et al., 2011; Gray, Saggers, et al., 2010; Hayashida et al., 1989; Sannibale, Fucito, O’Connor, & Curry, 2005), in conjunction with findings from the analysis of the focus groups and interviews, and consultation with other services (Brett et al., 2014), ACCHS staff, and the ACCHS board, informed the design of the pilot outpatient detox program that was implemented in the alcohol and other drugs section of the ACCHS.

Withdrawal management was always initiated on a Monday or Tuesday to reduce the risk of complications occurring over the weekend. Clients were offered transport to the clinic each morning and the option of a home visit or phone call in the afternoon. The standard detox program lasted for 5 days and involved a daily dispensed, weaning regime of diazepam, along with thiamine, supportive counselling, and relapse-prevention planning. The following week, clients received medical follow-up, and counselling or other follow-up as appropriate. They received follow-up phone calls from clinic staff at 2 and 6 weeks.

The ACCHS relied on usual staff of the ACCHS, plus an additional half-time alcohol and other drugs counsellor. Staff identified individuals who could potentially benefit from alcohol detox from within the ACCHS patient database and sent them letters advertising the new service. Promotional and educational activities were also undertaken within the ACCHS and through local media.

Clients could be referred for initial assessment for the program if a staff member suspected they had an alcohol use disorder. Clients could also self-refer. Attempts were made to provide same-day assessments by the clinic coordinator and a general practitioner to determine suitability for outpatient detox using national guidelines (Haber et al., 2009). In brief, patients were eligible if they were considered to be at risk of alcohol withdrawal, had no past history of severe withdrawal (including seizures or delirium tremens), no other active substance use (other than cannabis), no unstable medical or psychiatric illness, and stable accommodation with no drinkers at home. The presence of a support person was also preferable.

If considered suitable, the client was informed about the program. A relapse prevention plan was formed before initiating treatment. For those considered not suitable for outpatient detox, referral to residential services was offered. The program had the capacity to accept one to two clients per week.

Experience of Clients and Staff in the Pilot Phase of the Program

Clients and staff identified a number of advantages to outpatient detox delivered through an ACCHS, but challenges and suggestions for improvement were also identified.
Challenges and advantages of an outpatient or home setting for detox. As anticipated by stakeholder consultation, the home setting meant potential isolation and lack of 24-hour support for the drinker: “They came out to your house to see you, but I had a lot of time for thinking … with boredom you end up thinking, thinking, thinking and back on the grog” (CL4).

The same client valued being able to develop life skills and self-efficacy on his own terms and own environment: “If you don’t get out and learn and things—skills of mingling again—it won’t happen” (CL4).

Accessible and streamlined care. The program was designed to streamline the treatment process. One client expressed his satisfaction with this aspect: “So I had one appointment in the morning and at lunchtime I was at [the ACCHS] and I was on the program” (CL2).

Satisfaction was expressed with the provision of transport to and from the program.

Time spent talking in the car while being transported to and from the clinic was also seen as important by both clients and staff to engage clients in relapse prevention in a non-threatening environment.

Integrated and ongoing care. All eight clients completing the program remained engaged after treatment at 6-week follow-up, with five remaining abstinent until that time. This included accessing counselling, taking relapse prevention medications, or, in one case, transitioning to residential rehabilitation immediately after detox.

Holistic care. While engaged with the program, clients described how other health and social needs were addressed. Two of the clients described that their mental health problems were identified and treated. “They gave me other medications for … because I was really, really depressed because I hadn’t seen my daughter for at least six and a half months” (CL2).

One client described how he was able to access hearing aids, ophthalmology services, and a dietician.

All clients were registered with the “Close the Gap” scheme (Australian Government Department of Human Services, 2016), which provided the diazepam or other medicines at subsidized rates. Two of the clients were also able to register for a state debt repayment scheme in which their treatment involvement could be used to reduce state debt (NSW Office of State Revenue, 2016), and one was able to register for a parenting course.

A period of sobriety allowed two of the clients to engage with men’s groups, one of which elected the client to its board of directors.

Commitment to community and optimism. One client expressed the importance of both community support and giving back to the community: “Doing regular with that [the men’s group]—that’s helping me communicate with kids and get it into their head don’t drink, look what I’ve gone through” (CL4). A sense of optimism was conveyed: “At the end of the tunnel there is a light; there is goals to be achieved” (CL3).
Interactions with staff. Clients were all satisfied with the verbal and written information they were given. They felt staff were compassionate, approachable, and honest: “I didn’t feel intimidated or inadequate at all, didn’t feel pressured or embarrassed” (CL2). They also valued home visits. Often this was seen as a break from boredom and isolation.

Staff perceptions. Staff reported no major adverse events during the pilot phase of the program, and in particular no seizures or overdoses from the combination of alcohol and benzodiazepines.

Staff generally felt positive about the pilot program; however, they felt that clearly defining roles and responsibilities with early managerial support was important. Some medical staff felt that for selected clients, a less intensive model of care could be adopted with fewer clinic visits.

Diazepam dispensing processes were perceived to be a challenge, particularly as regulations required dispensing to be done in the presence of a medical officer or by a pharmacist. Near the end of the pilot program efforts were made to streamline the dispensing process by forming relationships with a local pharmacist, who could provide the medicines in advance in a Webster-pak (Elliott, 2014). This pack could then be cut into strips (appropriately labelled), and nurses could hand one strip to the client daily. Other clinic processes were streamlined as the evaluation was conducted, including reducing or deferring non-core assessments or paperwork until after withdrawal.

Identifying clients who could be suitable for the clinic was also a challenge. Staff felt there were many clients within the ACCHS who had an alcohol use disorder but had not yet been identified or offered assessment.

Staff expressed satisfaction with improved links that had been built with local mainstream residential and hospital services as part of the program development. This allowed rapid access to mainstream withdrawal and rehabilitation services when needed.

Quantitative feedback from satisfaction surveys of the first clients. Eight clients had 12 episodes of care during the pilot phase of the program (two had two episodes and one had three). After each episode, clients were able to complete an anonymous satisfaction survey. Ten surveys were received. All surveys indicated that clients were satisfied or very satisfied with the program. They all indicated they felt welcome in the clinic and were happy with staff providing the service and with information they had received. All would consider repeating the program if necessary and all would recommend it to a friend. All clients reported they were offered follow-up. Clients stated in feedback forms that they appreciated the chance to have a break from drinking and the help they received.

Discussion

Study participants expressed a pressing need for improved access to alcohol detox services for Aboriginal Australians. This is consistent with previous consultations with the...
Aboriginal community and with service providers (Gray, Stearne, et al., 2010). Various models of outpatient alcohol detox for general populations have been shown to be safe and effective (Alwyn, John, Hodgson, & Phillips, 2004; Blondell, 2005; Carlebach et al., 2011; Hayashida et al., 1989). This study involved a collaborative approach to developing a model of outpatient detox in an Aboriginal community, drawing on the unique opportunities for trust and accessibility provided by a community controlled health service.

Our study found a lack of community understanding of the medical management of alcohol withdrawal. Community discourse revealed the stigma associated with alcohol problems and treatment that involved being separated from community and locked away. These perceptions may echo similar traumas experienced within Aboriginal communities and are likely to pose an additional barrier to treatment access. A lack of understanding of the broad range of alcohol treatment options has been described in other contexts (Brady, Dawe, & Richmond, 1998). There is a need for community education on the full range of available alcohol treatments as well as on the role of outpatient detox specifically. Ideally Aboriginal champions within communities should provide this education to encourage open dialogue regarding alcohol issues affecting the community and encourage access to local treatment services.

The importance of services being sensitive to potential desire for involvement of family and community in treatment was also highlighted. This is consistent with previous studies of Aboriginal health (Teasdale et al., 2008). The model of outpatient withdrawal employed in this study appears to facilitate this involvement.

Concerns about other drinkers in the house did not seem to affect clients commencing the program. This may reflect careful screening of clients and their environment for suitability by staff. In the pilot phase of the program eight clients commenced outpatient detox. Five of these remained abstinent at 6-week follow up. Of these clients, all had been offered alcohol relapse prevention medication and were receiving psychosocial support either via counselling or support groups. Three clients relapsed to heavy drinking either during or shortly after the program (which was the reason for non-completion in all instances) and had further attempts at outpatient detox but eventually required residential treatment.

It was noted that despite the perceived magnitude of the drinking problem within the community, the rate of initial service use was low. Staff felt that enhanced screening and detection of unhealthy drinking within the primary health section of the ACCHS would help to identify clients with an earlier stage of dependence, a lower risk of complicated withdrawal, and therefore greater suitability for outpatient detox.

When establishing an outpatient withdrawal clinic it is important that staff feel supported by senior management, have adequate resources and training, and play clearly defined roles. There is also need for ongoing program evaluation and feedback to staff, clients, and community to assist in continual refinement of the model. The pilot program gave high priority to client contact, with twice daily face-to-face patient contact in most cases in order to minimize the chance of any adverse client event and maximize client support. This made the program relatively labour intensive. Where resources are limited, a less resource intensive approach may
be appropriate for selected clients. This may include pharmacy rather than clinic-based collection of medicines and omitting the afternoon home visit in cases where it is not deemed necessary. However, this model has not yet been evaluated in an Aboriginal context, and risks need to be carefully assessed.

While service changes require consultation and time, the process of developing a program such as this was observed to yield wider benefits such as staff skills development and improved relationships with mainstream services.

**Limitations**

This study has described the process of program development and early pilot evaluation. A larger study is required to more clearly delineate safety and effectiveness of this model of care; however, international evidence suggests that in carefully selected clients outpatient detox is a valid treatment choice. This study was conducted in a regional centre, and care must be taken in extrapolating these findings to rural and remote locations in which staffing and service availability may be limited and client health needs may be even more complex. However, the process of model development outlined here could be employed to develop locally appropriate models of care for outpatient alcohol detox.

**Conclusion**

This study demonstrated the potential for an Australian Aboriginal community controlled health service to provide outpatient alcohol detox treatment that is accessible and acceptable. Similar approaches to developing and evaluating a model of care for alcohol withdrawal may be valuable within other settings in Australia and in other Indigenous or marginalized populations worldwide.

**References**


Healing at Home: Developing a Model for Ambulatory Alcohol ‘Detox’ in an Aboriginal Community Controlled Health Service • Jonathan Brett, Angela Dawson, Rowena Ivers, Leanne Lawrence, Sarah Barclay, Katherine Conigrave • DOI:18357/ijih121201716906


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“I’m not really healed … I’m just bandaged up”: Perceptions of Healing Among Former Students of Indian Residential Schools • Tracey Carr, Brian Chartier, Tina Dadgostari • DOI:10.18357/ijih121201716901

“I’m not really healed ... I’m just bandaged up”: Perceptions of Healing Among Former Students of Indian Residential Schools

Abstract
Attempts at resolution between former students of Indian residential schools and the non-Aboriginal Canadian population began with the signing of the Indian Residential Schools Settlement Agreement in 2006. The Settlement Agreement outlined provisions for the Truth and Reconciliation Commission to document the stories of former students and for the Resolution Health Support Program to offer emotional and cultural support to former students and their families. Although former students have catalogued their stories through the Truth and Reconciliation Commission process, experiences of healing from the events of Indian residential schools remain relatively unknown. The purpose of this qualitative study was to explore the perceptions of healing among former Indian residential school students. In partnership with an Aboriginal support agency in a small Saskatchewan city, we interviewed 10 Aboriginal people affected by residential schools. The focus of the interviews was to generate participants’ conceptions and experiences of healing regarding their residential school experiences. We found all participants continued to experience physical, mental, emotional, and/or spiritual impacts of residential school attendance. Disclosure of their experiences was an important turning point for some participants. Their efforts to move on varied from attempting to “forget” about their experience to reconnecting with their culture and/or following their spiritual, religious, or faith practices. Participants also noted the profound intergenerational effects of residential schools and the need for communities to promote healing. The findings will be used to guide an assessment of the healing needs among this population in Saskatchewan.

Keywords
Indian residential schools, Resolution Health Support Program, healing, interviews, qualitative research

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Dr. Carr and Dr. Chartier collaborated on the design, analysis, and writing of this research and conducted the interviews. Dr. Carr wrote the first draft of the manuscript and Dr. Chartier provided revisions. Tina Dadgostari collaborated on the analysis of this research and provided revisions to the manuscript.

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Introduction
In an effort to aggressively assimilate Aboriginal children1 into white society, the government of Canada created the Indian residential school (IRS) system in the late 1800s. Approximately 150,000 First Nations, Métis, and Inuit children attended these schools that were funded by the government of Canada and operated by churches2 for decades, with the last closing in 1996 (Miller, 1996). Typically, children were taken from their homes, families, and communities and placed in residences. While former students have acknowledged some positive aspects of IRS, stories of sexual, emotional, physical, and spiritual abuse and neglect are far more numerous (e.g., Morrissette, 1994; Morrissette & Goodwill, 2013). Although not every child was abused in these ways, the experience of some degree of cultural annihilation was evident for the vast majority of students (Gone, 2013; Miller, 1996; Shewchuk, 2012). Children were systematically separated from their parents and communities and often suffered the loss of their native language and cultural practices (Legacy of Hope, 2014). Gone (2013) identified IRS impacts as complex, collective, and cumulative, affecting communities as well as individuals. These impacts have been characterized as a particular form of posttraumatic stress disorder called historical trauma (Braveheart-Jordan & DeBruyn, 1995; Gone, 2013; Shewchuk, 2012). Although the term historical trauma originated to describe the experiences of Holocaust survivors (Mohatt, Thomson, Thai, & Tebes, 2014), and its use has been criticized as being presumptive and reductive of the experiences of First Nations people (Kirmayer, Gone, & Moses, 2014), for the purpose of this study we employed the construct of historical trauma in a simple form—to mean psychological trauma and loss experienced as a result of involvement in a historical event (i.e., attendance at Indian residential school).

1 We used the term ‘Aboriginal’ in this paper to reflect the literature on the topic of IRS and to describe our sample. The participants in this study described themselves as ‘Aboriginal’.
2 The specific churches were the Presbyterian Church, the United Church of Canada, the Anglican Church of Canada, and the Catholic Church (Baxter v. Attorney General of Canada, 2006).
It has been argued that historical trauma has continued to affect multiple subsequent generations of Aboriginal people, even those who did not attend schools themselves (Legacy of Hope Foundation, 2014; Pearce et al., 2008; Tait, 2003; Waldram, 2008). For example, second-generation Aboriginal adults have reported higher levels of depression compared to Aboriginal adults without a parent who attended IRS (Bombay, Matheson, & Anisman, 2011). Other findings by Bombay, Matheson, and Anisman (2014) indicated that higher depressive symptoms in IRS offspring are influenced by their perceptions of past discriminatory experiences and considerations of Aboriginal heritage as central to their identity. Research in two British Columbia cities found sexual abuse in Aboriginal youth predicted negative health outcomes and vulnerability to HIV infection (Pearce et al., 2008). The authors linked their findings to unresolved historical trauma. In an on-reserve population health survey, Manitoba researchers investigated the mental health impact of residential school attendance on former students and their children (Elias et al., 2012). Direct or indirect (via parent, grandparent, or spouse) exposure to IRS was associated with a history of physical, mental, emotional, or sexual abuse/violence and suicide behaviour. The authors concluded that historical trauma operates at the individual, family, and community level (Elias et al., 2012).

To begin the resolution of the harm caused by residential schools, former students, with the support of the Assembly of First Nations and Inuit organizations, pursued legal action against the Canadian federal government and the churches. The result was the 2006 Indian Residential Schools Settlement Agreement, the largest class-action settlement in Canadian history. The agreement, which provided financial compensation to former students, called for the establishment of the Truth and Reconciliation Commission of Canada (TRC) and funded the Resolution Health Support Program (RHSP) to assist former students and their families during the resolution period (Government of Canada, 2016). On June 11, 2008, the Canadian prime minister publicly recognized the consequences of the IRS policy as “profoundly negative and that this policy has had a lasting and damaging impact on Aboriginal culture, heritage and language” (Government of Canada, 2008, para. 4). Official recognition of IRS impacts by the federal government was intended to be part of the beginning of reconciliation between Aboriginal and non-Aboriginal people in Canada (Government of Canada, 2008).

The establishment of the TRC, however, has not been universally acknowledged as a step forward. Niezen (2013) interviewed former IRS students as well as Oblate priests and nuns, and examined testimonies, texts, and visual materials produced by the commission. Niezen ultimately questioned the utility of the commission, suggesting there was little reconciliation with perpetrators because they did not attend TRC gatherings. He concluded that the commission was likely a political act to assuage victims without addressing the need for ongoing action to right the wrongs that have occurred.

While efforts have been made to recognize these harms and ameliorate their effects, there has been very little written in the research literature about the healing experiences of former IRS students. Stories about residential school experiences have been gathered by the TRC to acknowledge the experiences of former IRS students and to focus on the needs for healing (Truth
and Reconciliation Commission of Canada, 2015). It has been suggested that revealing the truth about residential school experiences can initiate the healing process (Reimer, Bombay, Ellsworth, Fryer, & Logan, 2010). However, details regarding what can continue to sustain the healing process for this population remain relatively unknown in the research literature.

It is useful to tease out some of the meaning in the concept of healing. Healing is a medical metaphor that is grounded in arbitrary and ethnocentric criteria (Comaroff, 1981). As Lavallee and Poole (2010) point out, “most advocates of mental health recovery are white with little attention given to culture and racism” (p. 272). They note that colonization has negatively affected Aboriginal Peoples’ health. They observe that Aboriginal people must go beyond Western notions of recovery and look at physical, mental, emotional, and spiritual well-being from an Aboriginal perspective. In this regard, the Legacy of Hope Foundation (2011) has identified some examples of promising healing practices that may be adaptable for Aboriginal communities.

However, the role that mainstream mental health providers could play in the promotion of healing among former IRS students and their families remains mostly unexplored. The ultimate goal of our research program is to understand the meaning of healing from the perspective of former IRS students to transfer this knowledge to mental health providers. The aim of the current study was to understand the healing experiences of a sample of former IRS students from First Nations communities in Saskatchewan.

Methods

Prior to commencement of the study we obtained ethics approval from the University of Saskatchewan Behavioural Research Ethics committee. Ethics approval was contingent on adherence to the Canadian Institutes of Health Research Policy Chapter 9 regarding ethics of health research with First Nations, Inuit, and Métis people (CIHR, NSERC, & SSHRC, 2014). In compliance with Chapter 9, we worked in partnership with the RHSP housed within a Saskatchewan Aboriginal organization. In consultation with Elders and RHSP workers, the program staff, we created the recruitment script, consent form, and interview guide. The program staff collaborated on the research design and played a key role in participant recruitment and data verification. The RHSP, established in accordance with the IRS Settlement Agreement (IRSSA), has provided emotional and cultural support to former IRS students and their families. One specific focus of the program has been to support individuals as they undergo adjudication proceedings related to IRS abuses, a provision of the IRSSA called the Independent Assessment Process.

The recruitment process began with RHSP staff approaching former IRS students from two First Nations communities that had received emotional and cultural support from their program. Program staff told potential participants that researchers from the university were looking for volunteers to take part in an interview study about healing from the impact of
“I’m not really healed … I’m just bandaged up”: Perceptions of Healing Among Former Students of Indian Residential Schools • Tracey Carr, Brian Chartier, Tina Dadgostari • DOI:10.18357/ijih121201716901

attending a residential school. Participants received compensation for their mileage and any childcare costs.

The researchers obtained informed consent from participants and conducted the interviews on three separate occasions at the organization. The researchers who conducted the interviews had both clinical and research experience with former IRS students. Typically, the semi-structured interviews were conducted according to gender with the female co-author interviewing female participants and the male co-author interviewing male participants. Duration of the interviews ranged from approximately 45 to 75 minutes, with a typical duration of 60 minutes.

In addition to asking general demographic questions, the interview was designed to probe individual perspectives on healing (e.g., What does healing mean to you? What does healing mean when you think about your experiences of residential school?), perspectives on family healing (e.g., What role has your family played in your experiences of healing?), community perspectives (e.g., What do you think healing from experiences of residential schools means to the Aboriginal community in general?), and general perspectives (e.g., What do you think healing from experiences of residential schools means to the non-Aboriginal community in general?). Our intent was to understand what “healing” meant to former students; we did not ask specific questions about their own personal healing experiences. Participants were invited to offer further input at the end of the interview and were encouraged to ask any additional questions of the interviewer.

The RHSP workers invited 12 former IRS students to participate in the study. Of those invited, a total of 10 former students attended one of the three interview days at the RHSP location and all consented to participate. Six males (age late 40s to early 70s) and four females (mid-40s to late 60s) were interviewed. All participants reported registered Indian status, lived on a reserve, and had attended between 2 and 12 years at an IRS.

Data Analysis
All interviews were electronically recorded and transcribed. Each transcript was reviewed and compared to the original audio recording for accuracy. All transcript data were housed in NVivo v.10. Once verified, a transcript was read from beginning to end. This analysis was an iterative and incremental process repeated for each participant and then across participants. Field notes were maintained throughout the process. The process of maintaining field notes was to promote self-reflection and to guide discussion between the researchers.

We chose interpretative phenomenological analysis (IPA) to analyze the transcript data. IPA originated from the desire of psychological researchers to understand qualitative experience within the mainstream of psychology (Smith, 1996) and has expanded as an analytical technique to the field of health research (Brocki & Wearden, 2006). Based within the three fields of phenomenology, hermeneutics, and idiography (Smith, Flowers, & Larkin, 2009, IPA enabled us to focus on the particular meanings of healing for each participant (i.e., their responses to interview questions about what healing meant to them) while considering our interpretations of
their meanings (Smith, Flowers, & Larkin, 2009). Our awareness of our interpretations of what healing meant to participants was an important step in the analysis and required iterative reflection upon the data.

The process for data analysis was derived from a six-step description of IPA (Smith, Flowers, & Larkin, 2009): (1) reading and rereading the transcript, (2) taking initial notes, (3) developing initial themes, (4) searching for connections among emergent themes, (5) moving to the next case, and (6) looking for patterns across cases. In following this approach, after all the individual transcripts were read and general notes were made on prevailing meanings within each interview, we developed initial themes for each participant, and then made connections between participants. We noted important commonalities and differences in these meanings.

The Results section presents themes and interpretations gathered from the interviews. The quotations are verbatim from participant interview transcripts and de-identified using pseudonyms. As IPA principles recognize, the findings are inextricably tied to the researchers’ perspectives, ideas, attitudes, and experiences. Wherever possible these perspectives were identified and acknowledged. In cases where the researchers and participants do not share the same cultural background, the acknowledgement of these potential differences is particularly important.

**Relationship**

For this study, we entered into a written, collaborative agreement with an organization in a small Saskatchewan city that provides services to former IRS students. The agreement outlined the study’s purpose and protocol, and the roles of the researchers and the organization. How the findings would be disseminated was also stipulated. When analysis was complete, we met with the organization to discuss the findings. Two support workers who were former IRS students and the organization’s director provided feedback on the themes that we had derived. The purpose of this non-audiotaped session was to verify the findings and to offer the organization documentation from the study.

**Results**

We identified five themes and three subthemes from the participants’ interview transcripts (see Table 1). We found the themes were often interconnected and reflected the complexity of the perceptions of healing in this sample of former IRS students. For example, many participants considered disclosing impacts of IRS to be an important part of their healing process. For some participants, disclosure was initiated by spirituality/religion/faith or by reconnecting with culture. The relationship between these themes could also be bidirectional, where, for instance, disclosure of IRS impacts led to a reconnection to culture. Although not every participant described every theme displayed in Table 1, all participants identified IRS impacts.
Table 1

Integrated Themes Related to Participants’ Perceptions of Healing from Indian Residential School Experiences

<table>
<thead>
<tr>
<th>Theme</th>
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<tbody>
<tr>
<td>Impacts of IRS</td>
<td>• Unanimously, participants identified negative impacts  \</td>
</tr>
<tr>
<td></td>
<td>• In many cases participants did not report healing experiences  \</td>
</tr>
<tr>
<td></td>
<td>• Many participants described a loss of identity  \</td>
</tr>
<tr>
<td>Subtheme: Forgetting</td>
<td>• In some cases, alcohol was used in an unsuccessful attempt to forget the trauma—alcohol use only exacerbated the trauma  \</td>
</tr>
<tr>
<td>Disclosure</td>
<td>• Disclosure was a turning point, a critical element of healing that reduced the impact of IRS experiences  \</td>
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<tr>
<td></td>
<td>• Listening to others’ IRS experiences had the power to transform isolation and elicit change  \</td>
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<td>• Disclosure occurred in a formal (e.g., counselling) setting for some  \</td>
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<td>Reconnection with culture</td>
<td>• Closely tied with the ongoing process of spirituality/faith/religion  \</td>
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<td>• Helped to re-establish identity for some  \</td>
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<td>• Reconnecting with culture sometimes included formal counselling  \</td>
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<td>Religion/spirituality/faith</td>
<td>• For some, the spiritual beliefs of culture coincided with the spiritual beliefs of their adopted religion  \</td>
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<td>• Spirituality was an essential ingredient for healing  \</td>
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<td>Subtheme: Forgiveness</td>
<td>• Spirituality provided a path to forgiveness of oneself and others  \</td>
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<td>Moving beyond IRS impacts</td>
<td>• Some participants noted the importance of moving beyond IRS impacts, particularly for subsequent generations  \</td>
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<tr>
<td>Subtheme: Education</td>
<td>• Educating the non-Aboriginal community about the impacts of IRS facilitated healing  \</td>
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IRS Impacts

A central theme in our discussions with participants was not related to healing per se, but was indicative of the profound and lingering impacts of IRS attendance. Although we had been explicit in the focus of the study—that is, our intent was to understand participants’ experiences of healing from IRS impacts—participants repeatedly remarked about the long-lasting impacts of the events that occurred at IRS. One of the most poignant illustrations of the enduring consequences for participants was expressed in Brenda’s metaphor: “I’m not really healed … I’m just up bandaged up. … Different bandages. Different places.”

Similar to residential school impacts reported by the Truth and Reconciliation Commission (2015), such as loss of culture, language, and parenting skills, all participants identified negative effects of IRS attendance. Some of these effects were physical; others were psychological. A particularly harmful impact was loss of identity. As Sylvia described this loss:

And that’s the way I was. I was—with myself, like I couldn’t really take myself, see myself through, you know, [non-fluent] as a, as a person. Like, I didn’t know who I was. And that’s really bothered me, I guess, all these years. Like, I—’cuz I left my family for so long every 10 months out of every year for 9 years and just going back in the summer and trying to rebuild all the time... it, it gets to a person.... Pretty soon you don’t know who you really are, you know?... So I got lost. I was lost for a long time. And sometimes today I still feel like that.

Another female participant, Lynn, indicated how the impact of IRS lessened with talking about the experience. At the same time, her memories of residential school experiences did not go away:

It gets easier, it gets easier when you, you know, talk about it but it’s still in the back of your mind. And it still hurts. Because to me, you know, it’ll always be there. And, you don’t immediately forget, you know, what you went through ’cuz [non-fluent] you know, these flashes come along and you know, you remember this, you remember that.

Many other impacts were noted by participants, including trying to forget memories of IRS. Forgetting, While Lynn was bothered by flashes of IRS memories, other participants endeavoured to forget. One male participant, Charles, stated emphatically that, “healing is forgettin’, forgettin’ whatever happened…. Forgetting all that … 8 years of, you know, went through hell and all that.” Later in the interview, Charles indicated that he had tried to forget his residential school experiences, but this did not lead to healing:
[I] drank a lot. You know, tryna forget. So alcohol. And then when I sobered up, see ... only of myself, you know... I don’t think there was any healing, actual healing. I didn’t go to any healing sessions or anything.

Charles described that “drinking to forget” did not release the “stuff” locked inside him: “To be mad and drunk, thinking about all this stuff still locked in me. Just drinking to forget. Or just drinking to get drunk.” In other words, attempts to forget sustained and worsened the impact of IRS.

Turning Point: Disclosure

Trying to forget about IRS was common among the participants. Nevertheless, many of the interviewees described disclosure of their IRS experiences as the turning point when their healing process was initiated. For Marianne, disclosure was the key element that initiated healing from her IRS experiences:

And I don’t know why today people don’t want to talk about their story, ’cuz that’s the only way I feel better about myself, is to be able to help somebody else with what I’ve done. ’Cuz that’s a number one thing I started when I started healing. I had to face that. I had to deal with it, you know.

Marianne had strong views about the importance of disclosure from the perspective of the listener and the speaker:

Even if you don’t feel like talkin’, I said. Go and listen. ’Cuz by listening to somebody else’s story, you’ll gain a lot. Hey, I’m not the only one carrying this garbage, you know. You’ll feel stronger. And as far as these people that are not telling their stories, I think they’re gonna stumble. And stumble.

For Marianne, both talking and listening had the power to transform isolation and elicit change. Some participants had discussed their experiences with Elders or other former IRS students. For Howard, speaking with someone who had gone through similar experiences was imperative for healing:

Oh. I know—healing you have to talk and but—you have to talk with people that actually went through something that you went through. So that you know and that they experienced the same thing. Instead of talking, talking to somebody that doesn’t have an idea of what you’re trying to say. ... You know, and to talk about what’s bothering you, what’s eating you, you know. To talk about it, it, it lightens it. It makes you feel lighter.
For other participants, disclosure occurred in formal settings such as counselling. Sylvia described how her healing process began:

Well, I never really started healing until I started taking classes and, you know, upgrading myself and especially when I went through this, uh, counselling classes that I took—this family counselling and that’s when I started, you know, when I started on healing myself through talking—talking over my problems and talking about myself. And what I came through. And also I never really knew my culture until I was into my social work... And that’s when I started taking classes in Native Studies and that. And that’s a nice—you know—[non-fluent] started seeing myself probably in a different way.

Beyond the disclosure of participants’ experiences in residential school, there were other themes that were intertwined: reconnecting with culture, and spirituality/religion/faith as an ongoing process. We will review these themes below.

Reconnection with Culture
Participants described reconnecting with their Aboriginal culture as an important component of their healing experiences. In Kelvin’s experience, participating in his culture took the place of formal counselling:

Kelvin: Going to powwows and stuff like that and ... being around the Elders. Elders help a lot.
Interviewer: Around Elders? Do you talk with them?
Kelvin: Talk with them, yup. Yup. Sit with them and talk. We never actually did that, that part where we are supposed to go and look for a counsellor or something.

For Howard, his connection to his culture had therapeutic potential:

You go to places where, like powwows, that there—the music is soothing, it ... you know. It takes you back, it calms you, it relaxes you. And you always walk away feeling good about everything. Everything’s not so—you don’t have to get so mad about everything.

Sylvia, who felt she had experienced a loss of identity as a result of residential school, described the benefit of seeing herself as a “Native person”:

And we had healing circles and talking circles and we just literally, you know, went through, you know, whatever we could—and that helped me—that helped me some, anyway, you know and [non-fluent] I tried to—you know, started seeing myself as a
Native person and that I should be proud of who I am. And, you know, because like I could never be white. Although I, you know, lived the way ...

Cultural practices served an important social support function which bolstered participants’ perceptions of themselves as Aboriginal people. Another significant aspect of reconnecting with culture was the inextricable link with participants’ perceptions of their spirituality, religion, and/or faith as ongoing healing practices. Connecting back to their culture was like returning home, returning to what they missed and wanted but had not gotten. In so doing, they linked into social supports that were culturally embedded.

Religion/Spirituality/Faith as an Ongoing Process

In describing their personal healing practices, participants often portrayed an effective blend of spirituality, religion, and faith. Dennis explained how his spiritual beliefs from his culture and his adopted religion coincided:

I think probably spiritually ... But when I go— I use both cultures. The Anglican and my culture. ... And they say, how come you can, how can you do that? Well, you pray to one Creator. Both religions, when we’re praying to the same Creator as Indian culture and ... Anglican culture. That’s what I think of, I don’t separate both.

Jack also described a blend of formal religion and spirituality:

Go to church in the morning, pray. First thing. Pray at night, the last thing you do. [My grandfather would say] just when the sun is rising. Listen to the birds. Look at the sky. Thank the Creator you’re here. ... And always, always, thank, thank the Lord that you got up healthy.

Brenda demonstrated the relationship between her practice of rituals, such as prayer and smudging, and the diminishing effect of the pain of residential school:

It’s not going to last forever. The pain that we have that we go through and ... there’ll be a day when it won’t be anything anymore. And it’ll be just a distant thought. But it doesn’t mean that it’s totally gone. Like I said, there’s going to be days where you have a good day, everything is good, and then it’s just like a process. Like a cycle. And ... it keeps just kind of repeating itself but less and less. And for me, I just—I smudge and I pray. I have a good day and I pray for everybody. Like healthy, sick, in prison; I pray for my family and my friends. I think that things turn out. And that one day we won’t—that it just won’t hurt as much anymore. That it’s not something I think about every day.

In Marianne’s experience, spirituality was the essential ingredient for her “healing journey”:
You know, I’ve been on a healing journey now since 1980. And I’m still healing but I heal through people and God. I really believe in my spirituality.

Forgiveness. For some participants, spirituality could lead to forgiveness of self and others. A central part of spirituality for Dennis was forgiveness:

Dennis: Forgiveness is the one that Creator gave us to do. And how else am I gonna get to up there without friggin’ forgiving people.
Interviewer: When did you finally—when did you get to the point of forgiving?
Dennis: When I started going to church.

In the following passage, Brenda described her process of forgiveness:

And it’s learning to let—say basically learning to forgive myself. And forgive those that have hurt me. And maybe, like, to write letters—to write a letter and then just burn it... And just give it to the Creator. Is how I put it. ’Cuz there’s nothing you can do, really, to—to go back and change it?

Thus, one aspect of spirituality/religion/faith as an ongoing process was the need to forgive in order to move beyond IRS experiences.

Moving Beyond IRS Impacts

Participants spoke of the importance of changing IRS impacts for those affected and for subsequent generations. Marianne was emphatic about the need to overcome “residential garbage”:

The reason why I opened my heart and my life is because I want them grandchildren to work and change like my kids been worryin’ for the upteen years. I don’t want my grandchildren, my [inaudible] to go on living with them issues. Residential garbage!

Kelvin noted that “there’s still a lot of work and a lot of healing that’s gotta be done. Not just on our own part but with our children.”

Education about IRS impacts. To move beyond the impacts of IRS, participants identified the considerable role of educating the non-Aboriginal community. As an Elder in the community, Marianne had shared her IRS experiences with students at local schools. She described her perspective on revealing her story to the non-Aboriginal community:
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Just, you know, you gotta tell the truth! We’re not there to get pity. We don’t go there to go and get pity. But we want you to know what really happened to our Indian people. And why some of our brothers and sisters are still crawling the streets of [city].

By telling their story, their truth, these participants felt they had moved beyond the worst effects of having been in residential schools—effects they witnessed others still struggling with in ineffective ways.

Limitations

Because the participants were volunteers from two First Nations communities in Saskatchewan, our ability to generalize our findings to the larger population of former IRS students in Saskatchewan or in Canada is limited. Moreover, in our sample, the participants had attended different schools for various durations in separate time periods. Ideally, in qualitative research, the background characteristics of participants should be more homogeneous (Smith, Flowers, & Larkin, 2009). Despite this heterogeneity, we found striking similarities within this sample of former IRS students—particularly in their discussions of impacts and their views regarding the importance of culture and spirituality.

Another potential limitation of our study was that the interviewers were non-Aboriginal. This cultural difference could have affected the participants’ level of trust and the degree of disclosure during the interview. To manage this limitation, we were open with the participants regarding our previous experience with IRS and former students and emphasized the ethics of confidentiality and anonymity.

Discussion

Our findings coincide with historical accounts of Aboriginal people’s experiences of IRS (Grant, 1996; Miller, 1996). Our analyses indicate that while participants in our sample remained negatively impacted by the effects of IRS attendance, they were active in their efforts to continue recovering from the consequences. Prior to our involvement with these participants, they had already begun a “healing journey” discourse. For these participants, the beginning of change or improvement was initiated by disclosure of negative IRS impacts, and the process of healing ensued through a complex interaction of reconnecting with culture and specific spiritual or religious practices. A few participants indicated motivation to move beyond the IRS legacy for the sake of subsequent generations and noted the need to educate the non-Indigenous community about IRS impacts.

These findings highlight the importance of considering “healing” within the context of the harms experienced. These participants could not speak of how they moved forward until after they had described what they had moved past. Their pain, past and ongoing, was the context they acknowledged before they could describe the ways they were moving beyond the impact of having attended residential school. Moreover, these qualitative findings are parallel to
epidemiological studies of Aboriginal mental health in Canada, where mental health problems in Aboriginal populations have been linked to cultural suppression and forced assimilation (Kirmayer, Tait, & Simpson, 2009). In our study, we heard the lingering impacts on individuals and their attempts to move past those experiences.

For these former students, to cope with IRS experiences it had become necessary to apply frequent doses of spirituality, cultural practices, or “forgetting.” Participants who engaged in the spiritual and cultural practices used the term healing; however, for those who tried to forget, healing was not an appropriate metaphor to describe their experiences. Thus, it is important to raise the issue of how “healing” was articulated by this sample of former students. Certainly, some participants used the language of healing in describing how they had moved on. But many of the participants did not use “healing” to describe their experiences since IRS. Some of these participants described their experiences to frame painful memories without using the language of healing. Other participants said that while they could not forget, they were able to describe the ways in which they had disentangled themselves from the negative effects they saw as persisting in other former students.

Consequently, there appear to be problems in using the concept of healing in the context of the effects of Indian residential schools. For those who are labelled as “healed” or “healing,” their ongoing struggle may be ignored. More importantly, healing could be a blaming concept whereby the onus for moving beyond the past is placed on those who have not healed. The injured parties are then solely responsible for the healing of their own injuries. Thus, we suspect that healing is a colonial term. That is, asking former students of IRS if they have healed is another process of establishing control over Aboriginal people and blaming them for what has happened to them. As such, pushing the rhetoric of healing may have the potential to produce additional harm to at least some former students of IRS.

We had stated that the original goal of our research program was to understand the meaning of healing from the perspective of former IRS students and to transfer this knowledge to mental health providers. Baskin (2016) has discussed the risk of cultural appropriation when helping professionals “Indigenize” their work, noting it can be hurtful and dangerous due to misuse and misunderstanding. She points out that Aboriginal people have been living holistically, incorporating spirituality “since the beginning of Creation” (p. 23). Moreover, she notes the “power imbalance between practitioners and service users” (p. 37). Aboriginal and non-Aboriginal practitioners need to acknowledge these issues before embarking on service provision to Aboriginal Peoples. One possible antidote to these cautions is what Baskin refers to as self-reflexivity. Self-reflexivity is the process of examining how the effects of your values, beliefs, acquaintances, and interests influence your work. In this context, the effects of your race, socioeconomic status, and religious beliefs should be added. Building a good helping relationship for professionals involves an examination of what aspects of themselves impact service users (Baskin, 2016).

Finally, we want to consider the goal of transferring this knowledge to mental health providers considering the findings of this study. Mental health practitioners must be aware of the
ongoing impacts of IRS attendance. The participants in this study could not discuss healing without setting out the context. Disclosure was likely a turning point for these participants because of a pervasive hidden truth: You cannot heal that which you do not acknowledge. Mental health practitioners, themselves, must challenge their colonial beliefs. Further, when healing occurred for participants, it took place in the context of reconnecting to Aboriginal culture and spirituality. Mental health providers will need to meet with cultural mentors and Elders, and immerse themselves in Aboriginal cultures and spirituality, before looking at ways to move toward physical, mental, emotional, and spiritual well-being from an Aboriginal perspective (Lavallee & Poole, 2010).

Implications

Mandatory education regarding IRS history from kindergarten to Grade 12 was one of the TRC report recommendations (Truth and Reconciliation Commission of Canada, 2015). One of the participants in this study was involved in school visits to share her residential school experiences. She viewed this activity as helpful for her own healing and for the reconciliation process. Our findings suggest that education about IRS history may be a potential avenue of meaning for former students, their families, and the non-Aboriginal community.

The essential healing elements of restoring culture and enhancing spiritual practices have been recognized in other studies (e.g., Reading & Halseth, 2013; Waldram, 2008). In documenting these participants’ perceptions of healing, we have added to the imperative for the government to enact the TRC’s Calls to Action regarding health, language, and culture. We have also documented the role Aboriginal spirituality and religion played in some participants’ perceptions of their post-IRS experiences. Participants attended church and traditional ceremonies without apparent conflict between the practices. How former students reconcile religious practices and Aboriginal spirituality is worthy of further investigation.

References


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The Social Context of Alcohol Use Among Māori in Aotearoa/New Zealand: Reflections of Life Experiences of Alcohol Use by Older Māori

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The Social Context of Alcohol Use Among Māori in Aotearoa/New Zealand: Reflections of Life Experiences of Alcohol Use by Older Māori

Abstract
To broaden public health approaches to alcohol use, this study provides an initial exploration of the social context of alcohol use among Māori in Aotearoa/New Zealand, from the perspectives of older Māori. Utilising a Māori-centred research approach, face-to-face interviews were conducted with 13 older Māori people to explore their personal experiences of alcohol use across their lifetime. Thematic analysis was used to identify common themes that contextualised stories of alcohol use within a Māori cultural framework. Four themes were identified: alcohol use within (1) a sporting culture, (2) a working culture, (3) the context of family, and (4) Māori culture. These themes highlight the influence of social factors such as the desire to socialise and seek companionship; the physical location of alcohol use; the importance of social networks, particularly whānau (family); and the role of cultural identity among Māori. In regard to cultural identity, the role of the marae (traditional meeting place/s of Māori), tikanga (the right way of doing things), and the relationship of kaumātua (respected elder) status to personal and whānau alcohol use are highlighted as important focuses for further research among Māori in Aotearoa/New Zealand.

Keywords
Older Māori, alcohol, social context, thematic analysis, Māori-centred research, Indigenous, cultural identity, social networks

Glossary
Aotearoa: the Māori name for New Zealand
Hui: to meet, meeting
Kaumātua: respected elder
Kaupapa: theme, subject, programme
Koha: gift, present, offering
Mana: prestige, authority, power
Manaaki: principle of care
Mana Māori: Māori control, autonomy, and self-determination
Māori: Indigenous person or people in Aotearoa/New Zealand
Marae: traditional meeting place/s of Māori
Matua: respectful term for an adult and can be used to address a man or women
Tangihanga: funeral/s
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Tikanga: values, beliefs, customs, and practices; the right way of doing things
Whaea: respectful term for an older woman
Whakapapa: genealogy
Whakapiki tangata: enhancement, empowerment, and enablement of a person or people
Whakatuia: integration and interconnectedness
Whakawhanaungatanga hui: a meeting to establish relationships
Whānau: family

Introduction
Alcohol use is social in nature, influenced by values, attitudes, and norms of
cultural/social, gender, religious, ethnic, health, and political groupings (Cagney, 2006; Heath,
2007; Rehm et al., 1996). Research shows that alcohol use reinforces group cohesion, helps
integrate family and friends, promotes social solidarity, and works as a social lubricant (Beccaria
& Sande, 2003; Heath, 1995; Rehm et al., 1996; Social Issues Research Centre [SIRC], 1998;

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celebratory, social, relaxation, medicinal, and therapeutic functions. Alcohol use is also influenced by a range of social factors (Cagney, 2006; Sargent, 1983). Despite these understandings, alcohol use is often described from a public health perspective that focuses on harms, hazardous drinking, and epidemiological impacts (Cagney, 2006; Jayne, Valentine, & Holloway, 2010; SIRC, 1998). Its use among Indigenous people in particular is primarily framed within a public health perspective, which does not allow space for the exploration of the everyday social context of alcohol use.

The social context of alcohol use among Indigenous people around the world is often framed as negative, a social and health problem that needs to be addressed (Bjerregaard, Young, Dewailly, & Ebbesson, 2004; Hunter, 1993; Lemert, 1979; Lurie, 1979; Sagers & Gray, 1998; Seale, Shellenberger, Rodriguez, Seale, & Alvarado, 2002). Explanations for harmful alcohol use often draw on the effects of colonization (Frank, Moore, & Ames, 2000; Hudson, 2011; Marie, Fergusson, & Boden, 2012; Sagers & Gray, 1998), the influence of European settlers and frontier colonialists, and discriminatory legislation (Albrecht, 1974; Brady, 2000; Frank et al., 2000; Hudson, 2011; Hunter, 1993; Sagers & Gray, 1998). Another concern is that socially acceptable alcohol-related norms and behaviours are determined by dominant and non-Indigenous cultures that do not necessarily align with Indigenous understandings of alcohol use (Sargent, 1983). The limitations in current literature regarding Indigenous alcohol use raise questions around why Indigenous people’s alcohol use is framed only as problematic and by whom?

In Aotearoa/New Zealand, evidence from public health literature suggests that the Indigenous Māori people have distinct patterns of alcohol use that are associated with disproportionate alcohol-related harm (Bramley et al., 2003; Ministry of Health, 2009; Moewaka Barnes, McPherson, & Bhatta, 2003). There is very little research exploring the social context of Māori people’s alcohol use (Awatere, Casswell, Cullen, Gilmore, & Kupenga, 1984; Mataira, 1987; Sagers & Gray, 1998) and only one publication focussing on older Māori (Herbert & Stephens, 2015). International research suggests that older people view their alcohol use as a part of their everyday social life, in a convivial manner and as a source of enjoyment, relaxation, and leisure (Dare, Wilkinson, Allsop, Waters, & McHale, 2014; Immonen, Valvanne, & Pitkälä, 2011; Kim, 2009; Tolvanen, 1998). While research in Aotearoa/New Zealand indicates that significant proportions of the older population do engage in hazardous alcohol use (Khan, Davis, Wilkinson, Sellman, & Graham, 2002), there is evidence that sociodemographic variables are related to these patterns of alcohol use (Herbert & Stephens, 2015; Khan, Wilkinson, & Keeling, 2006; Stevenson, Stephens, Dulin, Kostick, & Alpass, 2015; Towers et al., 2011).

**Social Factors Influencing Māori People’s Alcohol Use**

The desire to socialise and seek companionship influences and reinforces alcohol use among Māori (Awatere et al., 1984; Clarke & Ebbett, 2010; National Council of Māori Nurses, 1988; Te Puni Kokiri [TPK] & Kaunihera Whakatupato Waipiro o Aotearoa, 1995). Māori report larger and more integrated social networks (Kumar & Oakley Browne, 2008) which may provide...
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more opportunities for social engagement and alcohol use (Clarke & Ebbett, 2010). However, very little research has explored these aspects of Māori culture in relation to the socialising factors of alcohol use. Herbert and Stephens (2015) found a significant and positive relationship between types of social networks and hazardous alcohol use among older Māori. Those who belonged to more private, self-contained networks were more likely to engage in hazardous drinking, whereas individuals with close relationships to friends, local family, and neighbours were not likely to report hazardous alcohol use. These findings suggest the importance of engagement in social life to the ways in which people engage in drinking.

Within Māori society, whānau (family) is the most fundamental social structure (Cunningham, Stevenson, & Tassell, 2005; Durie, 2004) and can contribute to positive health outcomes (Dyall et al., 2014; Kumar & Oakley Browne, 2008). Whānau may be whakapapa (genealogy) based or kaupapa (theme) based (Cunningham et al., 2005). Kaupapa-based whānau may comprise people from the same geographical location or a group of Māori sharing a common purpose (Cunningham et al., 2005). The primacy of whānau structure, close social ties, and collective support may be available for older Māori regardless of living arrangements (Durie, 1997a; Dyall et al., 2014) and should be included in research about alcohol use.

The location of alcohol use may also be important. Amongst Māori, marae (traditional meeting place/s of Māori) are popular locations for alcohol consumption (Awatere et al., 1984; Mataira, 1987; TPK & Kaunihera Whakatupato Waipiro o Aotearoa, 1995), and research could explore other important social locations of alcohol use among Māori people.

Numerous authors highlight the importance of a secure Māori identity as being central to the health and wellbeing of Māori people (Durie, 1997a, 2004; Robson & Harris, 2007). A secure Māori cultural identity encompasses the ability to access both cultural and physical resources such as Māori language, marae, and whānau (Durie, 1997a). Research findings are contradictory and suggest that the relationship between cultural identity and alcohol use is complex for Māori and other Indigenous peoples (Beauvais, 1998; Byron, 1996; Clarke & Ebbett, 2010; James, Kim, & Armijo, 2000; Oetting, Donnermeyer, Trimble, & Beauvais, 1998; Spicer, Novins, Mitchell, & Beals, 2003). Herbert and Stephens (2015) found that older Māori who reported a stronger Māori cultural identity were significantly more likely to engage in heavier drinking, and Clarke & Ebbett (2010) found that Māori cultural identification influenced frequency of drinking in a sample of Māori people in Aotearoa/New Zealand. Other literature has found no relationship between cultural identity and alcohol abuse (e.g., Marie et al., 2012). Herbert and Stephens (2015) argued that consideration of the relationship between cultural identity and alcohol use needs to be explored from a Māori cultural perspective and broader social context of alcohol use to understand how cultural identity may operate to influence alcohol use among older Māori people.

Research to date indicates that the desire to socialise and seek companionship, along with social networks, location of drinking, and cultural identity, may influence alcohol use among Māori. However, questions remain about how these social factors actually work to influence alcohol use. In this paper, we provide an initial exploration of the social context of alcohol use...
among Māori in Aotearoa/New Zealand. Older Māori shared reflective accounts of alcohol use over the course of their life journey, shedding light on interactions of culture and alcohol use.

**Methods**

A Māori-centred research approach, which seeks to understand phenomena from within a Māori worldview and in a way that empowers the research participants and Māori communities, was employed in this study (Cunningham, 2000; Durie, 1997b; Forster, 2003; Ruwhiu, 1999). Participants shared their experiences of alcohol use, which were embedded in a Māori cultural context, and data were analysed using a Māori cultural framework, revealing how Māori concepts and lifestyles shaped their experiences of alcohol use.

Māori-centred research advocates for good research practice using appropriate social science methods and is founded on three key principles: *whakapiki tangata*, *whakatuia*, and *mana Māori* (Dorious, 1997b). Briefly, *whakapiki tangata* encompasses the ideas of enhancement, empowerment, and enablement. This principle reinforces the notion that research should contribute to positive development for Māori (Dorious, 1997b), rather than reinforcing negative stereotypes or vilifying Māori for their alcohol use. This has implications for the setting of the research questions, objectives, and processes. In relation to this study, an exploration of the social context of alcohol use by Māori allows for a deeper understanding of the public health issues and potential solutions for addressing at-risk behaviour. The results have direct implications for Māori development and potentially contribute to improved health of older Māori people. In regards to research practice, *whakapiki tangata* requires researchers to adopt *tikanga* (proper values and practices), if appropriate, when engaging with participants. This includes creating an environment where participants can speak openly and share their stories without being judged. Finally, in the analysis of participant stories it is important to ensure that participant voice is privileged. This can involve using practices such as participants reviewing the transcripts or taking a collaborative approach to analysis.

*Whakatuia* is about integration and promoting interconnectedness between spiritual, social, physical, and environmental domains that are important to Māori (Dorious, 1997b). As Durie (2004) states, “there is no single domain—cultural, physical or social—that can lay claim to a monopoly on the life experiences of Māori” (p. 6). In the context of this study, *whakatuia* had implications for the types of data we were interested in capturing, including the spiritual, social, physical, and environmental dimensions of alcohol use. Questions and analytical frames needed to be developed to achieve this. It also meant valuing all forms of knowledge. For example, it was not always obvious during an interview how a story being shared was related to alcohol use. We included all reflections and narratives rather than shutting down conversations.

*Mana Māori* emphasizes the idea of Māori control, autonomy, and self-determination of Māori people. *Mana Māori* requires ethical research practice as covered by *tikanga* and a universal code of ethics. This means thinking through how Māori have control over the research process and protecting the knowledge that is generated (Dorious, 1997b). *Mana Māori* has
implications for research practice particularly in regard to how participants are recruited, interviewed, and involved in the creation of their stories. From the researchers’ perspective it meant ensuring that research practice did not belittle the participants or their gifts in any way, and respecting their wishes.

Within this framework, face-to-face interviews were used to provide a space for older Māori to share their experiences of alcohol use, allowing for the exploration of such realities from within a Māori worldview (Lee, 20095; Wirihana, 2012). Participants’ words are the focus of meaning within the research context (Mischler, 1995), which is congruent with the principles of Māori-centered research.

Participants

People who identified as Māori, who were aged 60 years or over, and who had consented to being invited for interviews, were identified in the Health, Work and Retirement longitudinal study database (see www.massey.ac.nz/hart/). These people were recruited in a manner consistent with tikanga. For example, whakawhanaungatanga hui (meetings to establish relationships) were held to inform potential participants about the project and the implications of involvement. Thirteen older Māori (seven men and six women) agreed to participate after attending these hui (meeting/s). Participants were invited to have a support person/s or whānau member/s present with them at all hui and were given the option of using a pseudonym to protect their identity.

Procedure

The Massey University Human Ethics Committee Ethical granted approval for all procedures prior to the recruitment phase. Potential participants were sent an information sheet and invitation to meet with the first author at a whakawhanaungatanga hui to discuss the research. Such gatherings establish relationships (Bishop, 1996); provide opportunity for face-to-face contact, important within Māori culture (Pere & Barnes, 2009); and highlight the importance of identity and connectedness among Māori people. These hui align with the principles of whakapiki tangata and mana Māori because they enable informed choice, in a supportive environment, about whether participants wish to be involved in the research.

The hui were held at a place of each participant’s choosing and were either in the participants’ homes (n = 11), in an office at Massey University (n = 1), or at the employment place of the participant (n = 1). All 13 people who engaged in these hui chose to contribute to the project. To adhere to appropriate tikanga (Hudson, Milne, Reynolds, Russell, & Smith, 2007; Pere & Barnes, 2009) and ensure respectful research processes that enhanced mana (prestige, authority, power) for Māori, food and drink were shared at each hui and koha (gifts) were given to all participants (Hudson et al., 2007). At the start of the interview hui, the interview and consent process was explained with opportunities for questions, and participants signed a consent form. A voice recorder was then turned on and the interview began.
Interviews

Semi-structured individual interviews of 25–120 minutes duration were conducted in June to October 2014, in venues chosen by the participants. Participants were informed about the research questions and then led the discussion and remained in control of what they shared to privilege their voice and story. Most began by talking about how their parents or family had used alcohol when they were young, and stories emerged about alcohol use across their lives and how this had changed over time.

Analysis

The audio-recorded interviews were transcribed for analysis. Eight participants requested to have their transcripts returned to them for review, prior to analysis. Two of these participants made major changes to their transcript, removing and editing information they felt uncomfortable with, but all agreed to share the final versions of their transcripts. Thematic analysis, as outlined by Braun, Clarke, and Terry (2006), was used to illustrate collective meanings and experiences (Bold, 2012; Braun & Clarke, 2006; Riessman, 2005). Thematic analysis suits a Māori-centered research approach because it “does not ignore the diversity of research methods … but it deliberately places Māori people and Māori experiences at the center of the research activity” (Durie, 1997b, p. 9). Using the qualitative analysis program ATLAS.ti (Version 6.2), data were coded based on recurring, repeated, and compelling ideas across the transcripts. Codes were also identified based on the level of importance or centrality to a particular story. The broader themes these codes sat within were then identified by considering repetition of ideas across codes or ways in which the codes were related.

This approach to data analysis revealed that alcohol use occurred in four key contexts (themes): sport, work, family, and culture. A decision was made to focus on these contexts to gain a deeper understanding of Māori people’s lived and social experiences of alcohol use. We specifically looked for the commonalities and differences across these contexts and how they influenced and shaped, or were affected by, alcohol use according to participants’ accounts.

Results

Participants’ stories of alcohol use were constructed within and around four core social contexts of their alcohol use—sport, work, family, and culture. Each context was equally important and forms a theme that will be described and illustrated with excerpts from the participants’ stories.

Alcohol Use Within a Sporting Culture

Participants described many of their alcohol experiences within the context of a sporting culture. The following excerpts provide examples of the “norm” of alcohol use within sports
teams, after playing a game of sport, or as part of sporting events. Matua1 A reflected on his early experiences of alcohol in relation to playing rugby:

*I suppose I had a drink when, on the weekend in the rugby season, when we were playing rugby, which was probably typical of a lot of people.*

From several participants’ perspectives, alcohol was associated with playing sport, as described by Whaea2 Y:

*I played a lot of sport in my life; we were a sporting family, and alcohol and sport just seemed to go together. ... So it was accepted that with sport, and we played a lot of sport all seasons, after you finished you went to the clubrooms or to the pub or to somewhere and you drank.*

**Alcohol Use Within a Working Culture**

Participants also talked about how alcohol use was embedded in their working lives, and for some, their working environment was where the majority of their experiences of alcohol use occurred. Stories showed how alcohol use was part of the socialising practices in specific working cultures within industries such as shearing, freezing works, forestry, and railways. For example, Matua M said:

*In the type of work I was doing, like working in the freezing works, everybody drank; that was a done deal. Especially after pay night; we used to get paid on Wednesdays. So, Wednesday night, that was a night at the pub, and then when I was out shearing it was the same.*

Whaea PC highlighted how shift work regulated alcohol use within her nursing cohort:

*Bascially I never drank at all until I started nursing ... and you get to know somebody and you’re all off duty so we’d go out or, because I wasn’t old enough to go to the pub, but the older ones would get the beer and we’d go and have a few drinks.*

For other participants, drinking cultures were shaped by their socialising duties as managers. In general, both men and women described how their work lives introduced them to alcohol use and shaped their drinking patterns.

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1 *Matua*; a respectful term for an adult and can be used to address a man or woman, was used as part of the pseudonyms given to male participants.

2 *Whaea* is a respectful term for an older woman and was used as part of the pseudonyms given to female participants.
Alcohol Use Within the Context of Family

Participants’ stories of their alcohol use often involved family life. Matua L reflected on his early experiences of alcohol use which occurred within his family:

*I was in the pub before I was 18; I mean you could only get in there when you were 18 and I think I was getting in when I was about 16 and a half, 17. But I was able to do that because I was going in with family and they put me in the middle of the group.*

Whaea Y also highlighted how her alcohol use was embedded within the context of her family, who ensured her safety:

*I remember going in [to the pub] with some of our uncles, all underage, but I have to say they watched us, uncles and aunties in the local pub.*

Several participants described positive memories of early alcohol use within the family, recalling fun, music, sociability, and laughter. For example, Matua T said:

*I remember we used to have a lot of parties when we were young kids. There was always beer there, but I used to like it, you know; my uncles and aunts, they were just brilliant people. They never fought or anything, there was no anger there. They just enjoyed themselves and they’re a musical family and guitars and stuff came out. It was really good; I enjoyed my teenage years even when I was a kid growing up.*

In contrast, other stories highlighted the problematic aspects and social hazards of alcohol use. Whaea A, for example, described her early impressions of alcohol as being embedded in the family context and something that she has worked to change for her children. Similarly, Whaea P observed her sisters’ alcohol use, which was heavy and regular, and as a result she largely abstained from alcohol herself:

*As my sisters got older, they left home. Man, could they hit the booze, and I didn’t like it.*

Matua MK was also exposed to heavy and regular alcohol use within his family from an early age. However, while he constructed positive stories of alcohol use within his family, these early experiences contributed to the development of his own attitude towards alcohol and, like Whaea P, he has largely abstained from alcohol throughout his life. The role of family within these stories was either as a facilitator or restrictor of participants’ alcohol use, and early experiences influenced the participants’ own views and experiences of alcohol use.
Alcohol and Māori Culture

This theme provides insight into unique features of the social context of alcohol use amongst older Māori. Participants’ stories incorporate aspects of Māori identity and cultural belonging that played a role in their alcohol experiences. The marae was identified as a key location where alcohol was used in social occasions such as tangihanga [funerals], weddings, birthdays, and whānau-based events. Within the marae, tikanga was described for managing alcohol use. Also, kaumātua (respected elder) status and perceptions of ageing as a positive life stage have important implications for elders’ alcohol use.

**Alcohol on the marae.** Participants supported allowing alcohol on the marae because it ensures people stay together for particular events and it provides a safe environment for the consumption of alcohol. With accommodation available, others described the virtues of being able to sleep at the marae. Woven through these ideas is tikanga, which guides appropriate and acceptable alcohol use and, more importantly, conduct at the marae. Matua L explained the issues:

> I went to a marae back home ... and we had alcohol in the dining room and that was for a function. So those sort of things I think you can [have alcohol]. Although at my marae there’s no smoking and no drinking. I used to find that quite hard because you go to somebody’s tangihanga, you like to go back and sit down and have a beer and play the guitar and sing whānau songs, but you can’t do that now. If you do that, you’ve got to go to somebody’s house and do it and you’re actually going away from the marae and leaving the whānau there, which is not the tikanga. You don’t do that, you all go together, all stay together.

Whaea Y added:

> The marae is a safe place to drink because someone will look after you. There is someone who will growl [to berate or scold] you, I mean we go round and if someone was to do badly and start to get into trouble we’ll just get one of the nephews to look after it or someone else will do it. ... So I guess I’m saying our marae, to me, is a safe place to drink.

Matua MK also described the practical aspect of alcohol at the marae:

> When I was a kid, out at the marae ... all I remember was all the parties that used to go on out there ... it was just slow drinking, having meals and laughing and playing the guitar and singing. But that used to last four days.
Tikanga was described as being central to and guiding alcohol use and conduct. Matua M outlined some of the common guidelines used to regulate the use of alcohol in the context of important events such as a tangihanga:

*The thing is, if there was like a tangihanga down there, they had certain rules for them and there was no drinking around the marae until ... everything’s finished; like when you’ve cleaned up, then yeah. They allowed you to drink inside what they call the cook house. But you weren’t allowed in the dining room or around the front.*

**Kaumātua status.** Within Māoridom, ageing is a positive life transition and participants described how they changed their alcohol use as a result of being seen as older Māori. Whaea Y said:

*Yes, my alcohol use has changed as I’ve gotten older. I’m supposed to be wiser and I want to be a role model for the grandkids too.*

The position that kaumātua have within their whānau has meant that their focus has changed and alcohol use is minimised as a result.

Participants also highlighted their ability to manage other people’s alcohol use due to their status. For example, Whaea Y described how, as an elder, she ensures tikanga is upheld at the marae during occasions where there is alcohol use:

*We do watch those that are drinking at the marae. If someone’s being naughty or rude to an elder we growl them; I can growl at the marae, you know, for the safety of people. So ... we’re watching; there’s always someone.*

**Discussion**

The four themes identified in older Māori participants’ interviews about their lifetime alcohol use suggest the importance of understanding the social context of alcohol use, and raise questions for ongoing research in this area.

Social norms of alcohol use were identified as embedded in the sporting culture and highlighted the socialising aspects of alcohol use after a sports game and among teammates and whānau. This finding supports indications in the literature about the social drivers of alcohol use among Māori (Awatere et al., 1984; Clarke & Ebbett, 2010; TPK & Kaunihera Whakatupato Waipiro o Aotearoa, 1995), and builds on understandings of how socialising and companionship may encourage alcohol use within specific social contexts.

Similarly, alcohol use was embedded in the socialising practices among workmates in particular working cultures such as the freezing works, shearing, and forest industries. Johnston (2007) states that “Māori have traditionally worked in occupations that have had a culture of
working hard and playing even harder, such as shearing, forestry, fisheries and the freezing works” (p. 18) and these particular occupations support socialising practices which involve alcohol use. Other aspects of working cultures, such as shift work, also influenced alcohol use by dictating opportunities to socialise with workmates. The desire to socialise with workmates is a driving factor for alcohol use within these working contexts.

Participants’ stories of alcohol use were embedded within the context of family, and their experiences were constructed as either positive or negative in relation to how they understood alcohol use by their families and how their families supported their own participation. Again, this theme highlights social factors such as connectedness, companionship, and socialising as reasons for alcohol use amongst Māori.

Findings build on recognition of the importance of location in the social context of Māori people’s alcohol use. Participants’ stories around sporting, working, and family cultures highlight the pub as a central place where companionship and socialising occur. Further, within the theme of Māori culture, the marae was identified as a significant social location where older Māori consumed alcohol on special occasions (Awatere et al., 1984; Mataira, 1987; TPK & Kaunihera Whakatupato Waipiro o Aotearoa, 1995).

Together, the four themes identified in this study highlight whānau as a key concept underpinning the social context of alcohol use for older Māori. In their stories, older Māori describe socialising and making connections with whānau, in this case sports mates, workmates, and whakapapa whānau, as vital to their social interactions, and alcohol is also present in these interactions. Connecting with, and having access to, whānau is identified as an important component of a secure Māori cultural identity (Durie, 1997a). If whānau underpins alcohol use then consideration must be given to the relationship between whānau and Māori cultural identity within these social contexts of alcohol use. Herbert and Stephens (2015) found a significant relationship between Māori cultural identity and heavy drinking. However, this relationship is complex; on the one hand, Māori who strongly identify with their culture may have a stronger sense of connectedness and access to their whānau and collective Māori social structures (Kumar & Oakley Browne, 2008). Therefore, they may attend more whānau-related social occasions, influencing their frequency of drinking and quantity consumed (Clarke & Ebbett, 2010). Conversely, seeking to connect to whānau as a way of strengthening cultural identity may also entail socialising with alcohol. In summary, there is a relationship between whānau, Māori cultural identity, and alcohol use, but key information is missing, namely the mediating role/s of whānau and Māori cultural identity with alcohol use.

These results provide insight into the importance of kaumātua roles within the social context of alcohol use. Within Māori society, there is a positive view towards ageing and older people (Durie, 1997a, 1999; Kukutai, 2006). The transition to kaumātua status is often marked by increased recognition on the basis of wisdom, experience, leadership, knowledge, and contribution to whānau and Māori communities (Durie, 1999; Kukutai, 2006). The current study supports these understandings as participants indicated wanting to be good role models for younger generations and this was connected with the idea of reducing their alcohol consumption.
These findings raise questions around the meaning of alcohol within Māori culture: if being a good role model is associated with being abstemious, does this mean alcohol use is “bad” within Māori culture? Or do broader societal ideas about the capacity, dignity, and responsibilities of elders contribute to older Māori reducing their alcohol use? These sorts of questions provide the basis for further research in this area.

Another important finding was the ways in which manaaki (principle of care) was enacted by participants within their whānau and Māori communities. Within the marae, tikanga was described as controlling or managing alcohol use among Māori, and participants often described their role as kaumātua in enforcing this tikanga. Mead (2003) states that one way of understanding tikanga is as a “means of social control … [because it] controls interpersonal relationships, [and] provides ways for groups to meet and interact” (p. 16). Within this understanding, there is provision for kaumātua to assist in reinforcing and regulating tikanga and therefore conduct within the context of alcohol use because of their respected status.

**Limitations**

This study is the first to explore the social context of alcohol use from the perspectives of older Māori. While valuable insight is provided into some of the ways in which alcohol use is part of particular social contexts, further research into these contexts and with a larger number of participants may provide a deeper level of understanding of how Māori people are using alcohol in their everyday lives.

When collecting stories of alcohol use across the lifetime, it would also be beneficial for future researchers to develop a stronger and more familiar relationship with participants over time. Due to the nature of the research topic some personal and sensitive information may not have been shared with the interviewer. Holding several face-to-face interviews and hui could therefore have led to more in-depth exploration of participants’ experiences of alcohol use.

**Conclusions**

This study highlights the influence of social factors which shape alcohol use among Māori. Health interventions which seek to promote the safe use of alcohol among Māori need to consider such social factors. In doing so, existing health initiatives and public health policy may be strengthened by better aligning to the social realities of Māori people and their alcohol use. Specifically, findings highlight whānau as a key social structure as well as the importance of kaumātua roles within the social context of alcohol use among Māori. Implications of this are that kaumātua could have a leadership role in contexts where alcohol use occurs to ensure safe alcohol environments for Māori and possible regulation of alcohol use within their whānau as well. Kaumātua leadership may also provide avenues to develop Māori-specific ways of ensuring alcohol is used more safely and positively within Māori culture, and the responsibilities entailed may reduce hazardous alcohol use, in turn enhancing health and wellbeing.
The Social Context of Alcohol Use Among Māori in Aotearoa/New Zealand: Reflections of Life Experiences of Alcohol Use by Older Māori • Sarah Herbert, Margaret Forster, Timothy McCreanor, Christine Stephens • DOI:10.18357/ijih121201716904

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Acknowledging the Māori Cultural Values and Beliefs Embedded in Rongoā Māori Healing

Abstract
An exploration of rongoā Māori (a system of Māori healing based on Māori cultural traditions) was conducted to ascertain the cultural values and beliefs of Māori, the Indigenous peoples of Aotearoa/New Zealand, that are related to Māori healing. A Kaupapa Māori approach utilising Māori cultural concepts throughout the research process guided the overall study design. Semi-structured narrative interviews were conducted in 2009 and 2010 with 17 rongoā Māori healers. The rourou Māori method of data analysis, a 3-step process created specifically for this project, was employed to analyse healers’ talk about the underlying concepts of rongoā Māori healing. Two key topics emerged: concepts of healing, and the focus of healing. The importance of acknowledging Māori cultural values and beliefs inherent within rongoā Māori healing concepts and the focus of healing is discussed.

Keywords
Healing, health, wellbeing, illness, disease, Māori, spirituality, New Zealand

Glossary
Aotearoa: New Zealand
aroha: love
atua: god/s
awhina i te hunga mate: helping the dead
hara: transgression
hauora: health
hinengaro: mind
hononga tangata ki te rongoā rākau: connection between the healer and the plant
karakia: prayer/s
karanga: call
Kaupapa Māori: research conducted in alignment with Māori cultural customs
kawakawa: Macropiper excelsium, a native New Zealand plant
mahi: work
makutu: sorcery
marae: traditional meeting places
mātauranga: education
mate Māori: Māori spiritual illness
mauri: life essence
mirimiri: massage
Acknowledging the Māori Cultural Values and Beliefs Embedded in Rongoā Māori Healing • Glenis Mark, Kerry Chamberlain, Amohia Boulton • DOI:10.18357/ijih121201716902

nāu te rourou, nāku te rourou, ka ora ai te iwi: proverb meaning “through your basket of food, and my basket of food, the people will be fed”

noa: common
Papatuanuku: Mother Earth
rākau: trees, plants, and herbs
Ranginui: Sky Father
ritenga: rituals
romiromi: deep tissue manipulation
rongoā Māori: a system of Māori healing based on herbal remedies
rourou: basket (in this context, is used to refer to the Māori method of data analysis used in this research)
Tanemahuta: god of the forests
tapu: sacred
te reo Māori: Māori language
te wairua o te rongoā Māori: spirituality of rongoā Māori
tikanga: customs
tinana: body
tıpuna: ancestors
tohunga: traditional healer/s or priest/s
tuakana: elder relationship
urupa: cemetery
wai: water
wairua: spirit/spirits
wairuatanga: spirituality
whaiora: patient
whakanoa: purification or conciliation
whakaora i te hunga ora: healing the living
whakaora tangata ki te tangata: interpersonal healing
whakatauki: proverb
whakawatea i te whenua: clearing the land
whānau: family
whatumanawa: emotional
whenua: land

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Introduction

Rongoā Māori

Rongoā Māori (RM) is a system of healing techniques that has a long history of practice by Māori, the Indigenous peoples of Aotearoa/New Zealand (NZ). These healing techniques are based on Māori cultural customs and beliefs that have been passed down through generations. However, whenever there are shifts in societal structure, such as those arising from the process of colonisation, there is a series of concomitant changes in all aspects of Indigenous cultures. As one of the first articles to position RM within the research literature, this article seeks to provide a broad overview of the main concepts of RM healing and explore the cultural values and beliefs behind Māori healing processes. The relevance and significance of ancient traditional knowledges in a contemporary context is discussed.

Reporting this research requires us to use te reo Māori (Māori language) throughout the paper, in order to identify concepts and practices clearly. Māori language, and the concepts embodied in that language, are given primacy in this paper, in accordance with the overall premise that traditional knowledges must be protected, nurtured, and maintained through the academy. We have adopted the following practice for this use. The first time a Māori word or phrase is used, it is italicized (unless capitalized as a proper noun) and an English definition is provided in parentheses. Subsequent uses of the word are not so defined, but a glossary is provided.

Durie (1998) identified five different classes of Māori healing, noting that more than one type of treatment may be used at a time. According to Durie’s taxonomy, Māori healing includes ritenga (rituals) and karakia (prayers), rongoā (herbal remedies), mirimiri (massage), wai (water), and surgical interventions. In defining these historical concepts of Māori healing, Durie also noted that some of these skills (e.g., surgical intervention) have been lost or superseded, or are otherwise no longer used. Durie (1998) lists rongoā as one of many Māori healing techniques, one which involves the use of herbal remedies only. However, other academic sources (e.g., Jones, 2000a) cite mirimiri, karakia, and wai as aspects of rongoā and therefore as part of a traditional system of healing that has developed out of the cultural traditions of Māori.

RM is understood today to encompass the therapeutic use of medicines from herbs, trees, and plants in Aotearoa/NZ for a variety of therapeutic purposes (Durie, 1994; Macdonald, 1979; Parsons, 1985; Riley, 1994; Stark, 1979; Williams, 1996). RM involves the gathering, preparation, and formulation of plant materials including leaves, roots, and bark. These ingredients can be boiled and the liquid swallowed (Parsons, 1985) or the herbal barks, stems, roots, or blossoms can be steeped in water and the patient can lie in this herbal bath (Stark, 1979). Collecting these materials requires a detailed knowledge of the plants and their properties as well as the procedures necessary for gathering and preparing the plant substances (Kremer, 2006).

Māori beliefs surrounding the common, celestial origins of plants and humans include seeing both plants and humans as the offspring of Tanemahuta, god of the forests. In their traditional worldview, Māori see plant life as senior in status to people, because Tanemahuta
created plant life before mankind. As elder relatives, plants are seen as a link between humans and the sacred ancestors of Papatuanuku (Mother Earth) and Ranginui (Sky Father) (Riley, 1994). The incorporation of wairuatanga (spirituality), often in the form of karakia, is therefore an extremely important aspect of RM. Karakia are offered and tikanga (customs) observed to ensure the appropriate Māori rituals and traditions are upheld before, during, and after the healing is conducted (McGowan, 2000). The importance of wairuatanga also explains the need for observance of spiritual rituals before the collection and use of herbal materials (Riley, 1994).

While in the contemporary context RM is most often associated with the use of herbal medicine, it also involves physical therapies (Jones, 2000a) such as mirimiri and romiromi (deep tissue manipulation) (O’Connor, 2007). Each of these therapies involves applying pressure to various parts of the body to release and remove toxic build-up and waste (O’Connor, 2007). Detailed knowledge of pressure points, nerve centres, and muscle tissues is required. RM is also described as a holistic system of healing comprising a range of diagnostic and treatment modalities and embodying wairuatanga alongside physical, mental, and social aspects of health (Ahuriri-Driscoll, Baker, Hepi, & Hudson, 2009). Therefore, RM may be best understood as encompassing all aspects of Māori healing, as well as health. These aspects of health are founded on Māori cultural values that also provide the foundation for Māori healing practices.

Understandings of health and illness are founded on the beliefs and values held by a particular society (Capstick, Norris, Sopoaga, & Tobata, 2009). As societies change and adapt, so too do understandings of the causes of health and illness. In the NZ context, in the period before colonisation pre-1840, healing traditions were well established. However, in the process of colonisation much of that traditional knowledge has been lost.

Pre-Colonisation and Contemporary Understandings of Health and Illness

Māori health and causes of illness were once understood through the values of tapu (sacred) and noa (common) that regulated all of society and maintained harmony (Durie, 1998). For Māori, health was achieved through staying within societal bounds by obeying the lore of tapu to remain in harmony with people and with the environment. Illness would occur when any rule of tapu was broken, such as touching an object deemed tapu. Disease was understood to be bound intimately with the supernatural realm and had no natural cause. Diseases were invisible and were feared as signs from the atua (god/s) of displeasure at transgressions against one of their many laws of tapu. Any departure from normal health meant Māori had committed a breach of tapu which was considered an offence committed against the spiritual realm. The only other way that Māori could become sick was if they were the subject of attack by spirits through makutu (sorcery) (Metge, 1967).

Locating the type and cause of illness was once limited to discovering what transgression had been committed against tapu restrictions, and had in turn violated the gods. Tohunga (traditional healer/s or priest/s) would identify both the transgression committed and the avenging spirit to diagnose the illness (Buck, 1949; Lange, 1999). The tohunga consulted the atua during diagnosis, who revealed the hara (transgression) through dreams or prophecy, even if the patient was unaware of any transgression (Buck, 1949).
Healing treatment involved invoking the appropriate ritual, called *whakanoa* (purification or conciliation), that needed to be conducted to nullify the breaching of tapu, whether deliberate or accidental (Irwin, 1984). Treatment, once the tohunga had identified the god who had been offended during diagnosis, could also involve the tohunga commanding the evil spirit to depart (Buck, 1949).

Nowadays, in addition to the transgression of tapu, illness is attributed to a wider range of causes. While healers believe that spiritual illnesses such as *mate Māori* (Māori spiritual illness) or negative entities can cause people to act destructively, illness is also understood to be related to dysfunction in the mind/body connection. Unresolved emotional issues from childhood and negative thoughts are believed to manifest as disease (Mark, 2008; Mcleod, 1999). Ill health can also be related to an imbalance between physical and spiritual aspects. For example, some people may place too much emphasis on the physical aspects of life, neglecting their spirituality and connections with their Māori culture.

A study by Jones (2000b) investigated the way Māori healers diagnose their patients and compared and contrasted it to Western medical methods of diagnosis. The classification of diagnoses was based on five cornerstones of Māori healing—*wairua* (spirit), *hinengaro* (mind), *tinana* (body), *whānau* (family), and *mātauranga* (education)—with a distinction drawn between physical and spiritual diagnoses. Whilst Māori healers in the study employed similar diagnostic processes to Western medicine, they differed from the majority of Western medical practitioners in that they took a holistic approach to patient wellbeing, aiming to influence all aspects of a patient’s life with an emphasis on the spiritual. This approach was viewed as consistent with their beliefs about health and causation of illness emphasising the spiritual dimension (Jones, 2000b) and provides an example of how traditional etiology of, and diagnosis through, spirituality has remained in use in Māori healing today.

Recent research suggests that Māori healing focuses on creating change in the mind, body, and spirit of the patient (Mark, 2008), with healers viewing themselves as a tool, vehicle, or channel for the healing energy that comes from such entities as God, Christ, the holy spirit, *tīpuna* (ancestors), and/or spirit guides (Mcleod, 1999; Mark, 2008; Rae, 1997; Tito, 2007). That healers see themselves as a tool or channel demonstrates a view of healing that has a sustained focus on spirituality. Spiritual gifts, including high sensory perception beyond the normal range of human senses, divine insight and guidance, and inner feelings and knowing, are used throughout healing practices (Mcleod, 1999). Karakia are used for the benefit of both the healer and patient (Goldie, 1999; Macdonald, 1979; McGowan, 2000; Mcleod, 1999; Tito, 2007). Constant communication with *tīpuna* is also employed before, during, and after the healing session (Loesel, 2006). In previous research on RM, participants reported using karakia as a multi-purpose remedy in conjunction with herbal medicines. It was used to treat various conditions and illnesses (Sporle, 1994).

In pre-colonial times, RM was the exclusive domain of tohunga, who were crucial to the lawful and spiritual upkeep of Māori society. However, the passing of the Tohunga Suppression Act in 1907 was aimed at greatly reducing tohunga practice (Lange, 1999). The act was a very
deliberate attempt on the part of the government to ensure that all healthcare in the country was based on Western concepts and methods. Māori leaders of the time, such as medically trained doctors Pomare and Buck, supported the Tohunga Suppression Act, as they believed in the advantages that medical science could offer Māori and thought that tohunga were ineffective in dealing with the health of Māori (Durie, 1998). It was argued that Māori health and wellbeing must be protected against tohunga, who claimed to have supernatural power to cure disease (Voyce, 1989). The Tohunga Suppression Act weakened Māori confidence in Māori approaches to healthcare. However, because tohunga represented a link with the past and with traditional authority, many Māori continued to consult them. Also, in spite of the Tohunga Suppression Act, Māori healers continued to pass their healing abilities on through the generations (Mcleod, 1999; Tito, 2007), and belief in RM and spirituality remained intact amongst many Māori communities.

In contemporary times, the status of Māori healers has changed; whereas they once occupied a central role in society, traditional healers today are regarded as part of the “alternative” or complementary forms of health treatment. Most Māori now turn to the Western medical system when requiring health treatment (Durie, 2001). In addition, the way that healers are chosen has changed; Māori healers may not be trained in the same way that tohunga were in traditional Māori life, through being chosen as children and taught by other tohunga. However, healers are still often brought up knowing how to use Māori medicine to treat illness as a way of life (Kominik, 1993; Tipene-Leach, 1994; Tito, 2007). The change in status of Māori healers from being central in society to now occupying a more marginalised position in the health sector can be attributed to many systemic causes, such as colonisation, the Tohunga Suppression Act, and the Westernisation of health treatment (Jones, 2000a), as well as to the rapid decline of the Māori population as a consequence of colonisation. Nevertheless, Māori healers continue to practice RM despite their change of status in society. The more marginalised position that healers now occupy in Māori society may go some way to explaining shifts in perspectives about concepts of healing.

Contemporary understandings of traditional RM and the practices and processes of tohunga have been derived largely from oral history, some written historical accounts, and knowledge passed down in healing families. While knowledge of the various RM healing techniques has been gathered from these sources and described in the academic literature, research into the beliefs underlying the healing practices of Māori healers has not been undertaken. The study described here involved contemporary Māori healers and sought to ascertain their understandings and perceptions of rongoā Māori. It provides a valuable exploration of the cultural values and beliefs that underlie RM healing processes in a modern context.

**Methods**

This research was conducted according to a Kaupapa Māori approach, a manner of conducting research based on Māori cultural understandings and values (Powick, 2002; Smith & Reid, 2000). Kaupapa Māori ensures that ownership and control of Māori research and
knowledge remains with Māori (Walker, Eketone, & Gibbs, 2006), addressing issues of self-
determination, legitimacy, and authority (Bishop, 1996). In practical terms the Kaupapa Māori
approach guided the research processes, facilitated the building of rapport with participants, and
allowed for reciprocal relationships to emerge (Powick, 2002). The research was approved by the
Massey University Human Ethics Committee [09/026].

Seventeen rongoā Māori healers, all of whom were Māori, who self-identified as RM
healers and who had treated patients other than their own whānau, agreed to participate. This
research utilised both snowballing and purposive methods of recruitment (Bowling, 2009). Once
an initial group of Māori healers was identified and agreed to participate, they were also asked to
recruit others. The limitations inherent in these sampling methods may, in turn, have led to a
biased sample, as participants were recruited from specific networks. However, those Māori
healers involved were purposely and necessarily chosen because of their expertise in Māori
healing. Participants were identified and recruited by the first author and through friends, family,
and social networks of the first author. Five males and 12 females were involved in the study,
with ages ranging from 43 to 76 years. The majority of participants were from the North Island
of Aotearoa/NZ, with one participant from the South Island. Healers used a wide variety of
healing techniques including, but not limited to, herbal medicines, mirimiri, romiromi, spiritual
healing, and counselling.

The first author conducted one semi-structured interview with each participant between
October 2009 and December 2010. Each interview was held at a time and place convenient to the
participant and was recorded and transcribed. The first author allowed for flexibility in the
conditions of the interviews according to participants’ needs, which resulted in interviews being
conducted in a variety of venues and situations. Nine interviews were held at a participant’s own
or another’s home; four interviews were held at cafes; three at hauora (health) clinics based at
marae (traditional meeting places); and one in a university office. Only five interviews were
conducted with the participant alone; all other interviews had other people present, including
spouses, friends, or family. This was not planned but provided participants with support and was
encouraged by the first author. The interview focused on participants’ experiences of RM
healing, their views of the underlying concepts of RM, and their concepts of health, illness, and
healing. At the end of each interview, the first author and participant(s) shared a meal, in
accordance with Māori custom, where sharing food is an important aspect of forming
relationships with others.

Analytical Framework

A culturally informed analytical framework was created specifically for the purposes of
this research. The framework is based on a Māori whakataukī (proverb), “nāu te rourou, nāku te
rourou, ka ora ai te iwi,” metaphorically interpreted to mean “through your basket of knowledge
(nāu te rourou) and my basket of knowledge (nāku te rourou), the collective basket of knowledge
will expand (ka ora ai te iwi).” Using a well-known proverb as a cultural frame of reference
meant that the analytical process was flexible enough to incorporate the findings gleaned from
interviews with individual healers, the first author’s reflections on individual interviews, and the first author’s reflections on the collective story of rongoā Māori.

Step 1 (nāu te rourou) involved reviewing the transcripts of each individual healer’s interview for their understanding of the meaning of RM healing in their experience. This step acknowledged each healer’s unique perspective and provided initial concepts for the data analysis process. Sections that specifically related to the research questions were extracted. Analysis focused on identifying important elements of healing and the healer’s understandings of the main, underlying philosophy of RM.

Step 2 (nāku te rourou) involved further analysis of the data which acknowledged the first author’s perspective and interpretation of the interview data. During this step, the first author collated the initial categories identified in the first step across all participants and constructed more general, broad categories from the individual accounts of healers (cf. Josselson, 2011). This step acknowledged the involvement of the first author in making meaning of the stories of healers, as an intrinsic part of making this a collaborative data analysis process (cf. Powick, 2002).

Step 3 (ka ora ai te iwi) involved collating the healers’ opinions on the underlying concepts of RM to provide an overall picture of the knowledge of the healers as a collective group. In this step, the first author took the broad categories identified through the first and second steps of data analysis, and collated and compiled them into a series of underlying concepts on RM across all healers. Each step was conducted in order, with repeated reference to earlier steps and the interview data in order to maintain connection between the healer’s views and the data analysis process.

To ensure rigour, the first author used Whittemore, Chase, and Mandle’s (2001) concepts of credibility and authenticity. The data were read thoroughly and repetitively throughout the data analysis process to ensure that interpretations were accurate and corresponded to the meanings of the experiences of participants. In addition, the use of criticality and integrity meant that the first author maintained a reflexive attitude towards data analysis by being careful to avoid distortion of the data and by checking to ensure that interpretations were based in the data (Whittemore, Chase, and Mandle, 2001).

Consistency was ensured through a range of verification strategies (Morse, Barrett, Mayan, Olson, & Spiers, 2002). These included methodological coherence to ensure the research matched the research question, and sampling sufficiency where participants (Māori healers) were chosen who had substantial knowledge of the research topic, rongoā Māori. In addition, the process of data collection and analysis occurred concurrently, with theoretical ideas and theory development being assisted through constant analysis of the data, as well as the analysis process (Morse et al., 2002).

Results

As the data were reviewed, we noted that some subthemes related to the theory and practice of RM healing from the healers’ perspectives. Other subthemes related to the application
of healing to the patient and described the nature of the patient in a way that was new to the traditional healing literature. Therefore, the findings were categorised into two broad themes: concepts of healing and the focus of healing.

Under the “concepts of healing” theme we identified three subthemes related to essential components of healing:

**Subtheme 1:** Spirituality of rongoā Māori (*te wairua o te rongoā Māori*),
**Subtheme 2:** Interpersonal healing (*whakaora tangata ki te tangata*), and
**Subtheme 3:** Connection between the healer and the plant (*hononga tangata ki te rongoā rākau*).

Under the “focus of healing” theme we identified three subthemes that recognised different type of healings and described the nature of the patient:

**Subtheme 1:** Healing the living (*whakaora i te hunga ora*),
**Subtheme 2:** Helping the dead (*awhina i te hunga mate*), and
**Subtheme 3:** Clearing the land (*whakawatea i te whenua*).

Each of these topics is presented below with a brief discussion. Quotations provided to link these themes to the data are identified with pseudonyms for each participating healer, as noted in parentheses at the end of each quote.

**Theme 1: Concepts of Healing**

**Spirituality of rongoā Māori (Te wairua o te rongoā Māori).** A central feature of rongoā Māori mentioned by healers is spirituality, specifically communicating messages from their tīpuna, from past generations, during the healing sessions. As one healer stated: “It’s not really us that do the healing, it’s really our ancestors … connecting with the whaiora’s [patient’s] ancestors and … it’s really them that … do the work … cause everything is … spirit” (Ruia).

Another healer believed that “the spiritual dimension of healing in the wairua sense of healing … for me … is that our tīpuna are the wairua to give us messages to do the mahi [work], aye” (Atawhai).

For healers, a process of interpretation was required because it did not always involve using words; one healer noted that “you hear or you feel or you sense” (Rangimarie), and healers described being a channel rather than being the source of this information. The importance of spiritual communication was so significant that in the views of the healers, it was the tīpuna who were regarded as the actual healers, rather than the healers themselves.

This finding is supported by research on Māori wairua, which shows that communication with the ancestors is viewed as important in transferring knowledge between physical and spiritual realities (Valentine, 2009). This view is likely to originate from the Māori belief that humans are composed of the body, wairua, and mauri (life essence), and communication is possible between the body and the spirit (Henare, 2001). Healers become channels of the healing, an idea supporting McGowan’s (2000) claim that the power of rongoā Māori to heal is
through the wairua. Therefore, a core concept of RM is that healing is directed, guided, and conducted through wairua by the ōpūnana, and the healer becomes a mediator of the entire process.

**Interpersonal healing (Whakaora tangata ki te tangata).** It was important to healers that they build a relationship with the patient, rather than focus on treating the person’s illness.

_The first thing you do is ... you put that person at ease. ... You know, just the basic questions ... where do you live... what’s your situation at the moment ... and that’s just like a really basic diagnosis. ... What it does is ... it hones me down to the area where they’re from. And so I can connect in with that whenua [land]._ (Rangimarie)

Several healers insisted that the relationship between healer and patient needed to be based on _aroha_ (love) as an intrinsic aspect of the healing: “Aroha is the most important, powerful tool that’s ever used. Because your aroha’s gotta be with your patient ... because it’s part of your love that helps with the healing as well” (Kororia).

Although aroha is already understood as an intrinsic value in Māori culture, it has not been previously associated with rongoā Māori healing. While research on other forms of healing shows that healing is influenced by the impact of expectations between healer and patient about healing (e.g., Wirth, 1995), this expectation lacks the depth of the belief in the importance of people in rongoā Māori. RM is characterised as being about caring for, and healing, people who are sick, and not simply treating their illnesses. This indicates an underlying concept of RM as being primarily a “people medicine” (McGowan, 2000, p. 161). RM is conceptualised as a relationship-based treatment, grounded in aroha, which contributes to the interpersonal healing between the healer/patient.

**Connection between the healer and the plant (Hononga tangata ki te rongoā rākau).** Māori healers described the process of picking and preparing plants in RM healing as a mutual relationship between healers and plants.

_It’s ... a totally different world, rongoā, aye ... it’s normally a day process where karakias start at home and ... when you tramp the bush and ... you kind of connect with the ... tuakana [elder relationship], with the rākau [trees, plants, and herbs] while you’re up there ... there’s a lot of whatumanawa [emotional] stuff that happens between you and the rākau while you’re up there ... the stories that they can tell you. ... And ... as part of the rongoā ... process, we tend to recite their genealogy back to them ... and it’s that connection and ... the karakias and everything else that releases the ... magic, really. Because ... everybody can boil leaves but ... it’s becoming in tune with and releasing the ... magic of it and the potential of it._ (Ruia)

In this excerpt, plants are viewed as individual entities that are alive, are imbued with the ability to communicate, and have their own stories and genealogy. When the plant is taken, there
is an acknowledgement of the spiritual world, through karakia, to give thanks. Even though the life force of the plant is being taken, it returns to become one with people, signifying a reciprocal process between people and plants. The entire process is performed with honour and respect to the plants, which continues during the preparation of herbal remedies:

But you must put your prayer into it ... to make it strong for you ... you don't just go and take a rongoā and drink it. ... Because the karakia’s ... you gotta be really specific ... what you want your rongoā to do for you. Because ... the rongoā is like you and I, it understands us. So if you don’t give it any direction, so you may as well just drink water. ... This essence you put into it. And this is the ... special essence that we have that we put into that. (Kororia)

While the use of herbal material in rongoā Māori has been previously described (Mark, 2008; Sporle, 1994), there does not appear to be a similar description of a relationship between healers and plants in the literature. This relationship between healers and plants may be due to the belief of Māori healers in the ability of particular people to communicate with plants through their mauri (Henare, 2001; McGowan, 2000). This underlying concept of RM shows reciprocal mutual communication between people and plants that creates a synergy, which enriches the healer and enhances the potency of plants in Māori healing.

**Theme 2: Focus of Healing**

Within the focus of healing theme, we identified three areas that differentiate to whom healing can be applied and describe the nature of the patient. Healing the living (whakaora i te hunga ora) focuses on concepts of healing the mind, body, and spirit of patients, demonstrating the holistic nature of RM. Helping the dead (awhina i te hunga mate) refers to the work healers may do for people who have already passed away, challenging the idea that the purpose of healing is to shift a patient from a state of illness to a state of health. Clearing the land (whakawatea i te whenua) refers to shifting negative wairua from the land, challenging the idea that healing may be applied only to people.

**Healing the living (Whakaora i te hunga ora).** Healers related numerous examples of healing that showed physical, emotional, and mental improvements, or changes, for patients, thus illustrating the holistic nature of RM healing.

One healing example involved direct impacts on the physical state of a patient:

She had shingles. ... Took me couple of days to ... do poulticing on her with the kawakawa [Macropiper excelsium, a native New Zealand plant] ... where it was painful ... ’cause the doctor couldn’t do anything for the pain. ... I said, well, get some water from the sea and then bathe it when it gets itchy. Well, what she did, she went into the sea ... Well, that was only two days fixed, aye. (Kororia)
Some examples of emotional and mental healing related to simple shifts for the patient, such as from fear to acceptance:

There’s a lot of them that go there because they were scared to die. By the time ... you finished with it on the table, they’re asleep. They’re good as gold, and ... when they wake up, I say, “How you feel now.” Oh, good. They’re not scared anymore. (Hemi)

Several healers also related healing effects in which patients looked and felt peaceful:

He just seemed a little bit dark ... and he just needed ... some direction or something to boost him. He was looking for something ... he sort of opened up and ... was relating to me and ... it actually looked as though his cloud had lifted a little bit. ... It sounds simple, but you never know where people’s thoughts and actions are. ... When he left he was a lot lighter and he was more ... inspired. (Rangimarie)

These findings illustrate physical, mental, and emotional effects of healing for patients. In previous research with Māori healers, they believed that healing energy originates from the spiritual level, moves through the healer’s body, and then is sent to the patient to facilitate change and produce effects on the mind, body, and spirit of the patient. Whenever changes occur in the mind, the body, or the spirit, it creates change in all levels (Mark, 2008). The mind, body, spirit concept is a recent understanding of RM, because as noted earlier, traditional Māori healing focused primarily on spirituality as the main form of treatment (Buck, 1949). Therefore, this research finding extends on the traditional Māori healing focus on spirituality to indicate a new underlying concept of holistic healing where RM aims to influence, and heal, the mind, body, and spirit of the patient.

Helping the dead (Awhina i te hunga mate). Healers offered stories about healing the spirits of people who had already passed away. One healer described a situation where spirits of ancestors were used to remove malicious spirits that were causing death:

I said, “Hey, something’s wrong with your fulla’s [group of people’s] patient,” and then they have a look. She had completely died. And they, oh well, they panicked. ... I did a karakia and it was—things come to me so I had to ask for her tīpuna Ngāpuhi [name of an ancestor] to come and take that off because it’s ... their ... descendant, so that’s who I get to come down so he takes it out and it’s easy and the thing was, she had, um, what was it, lizards stuck in her throat. Yeah, and that’s what stopped her from breathing. The lizards. (Kororia)

This was a spiritual healing where the change created in this healing was to evict the spirits so that the patient wouldn’t die.
Several healers described another spiritual phenomenon where spirits of people who have passed away, become lost and attached to people, causing physical symptoms. However, these spirits, rather than being malevolent, have simply lost their way. One healer described the healing of a lost soul as follows:

I said to her, “What’s the feeling on your heart?” She said, “I am so cold.” When somebody tells me that they’re cold like that, I know that they have lost souls with them ... so I just carried on with what ... I was doing. ... She got off the table ... she said she was just so much warmer, she was [had been] like an iceblock. (Aroha)

In effect, this could be considered a double healing, for the lost soul as well as for the living patient. It would be very difficult for a patient to pinpoint a lost soul as a cause of pain in the physical body, especially without assistance from a healer with the ability to see into spiritual realms.

Healers shared how they must then work with these “lost souls … leading them to the light, showing them how. I talk to them and tell them there’s another, better, beautiful place that they can go to” (Kororia). For this healer, removing the lost soul by sending them to the light alleviated the patient’s symptoms.

Little research appears in the literature on traditional medicine healing people who have already passed away. The approach of Māori healers to healing spiritual entities or people who have passed away may be due to Māori healers’ belief that the physical world is impacted by spiritual laws (Valentine, 2009). Because healing the dead is undertaken, it becomes incongruent to say that healing always leads to better health. RM healing is therefore better understood as facilitating a process that creates change for patients, assisting them to achieve a different state of being.

Clearing the land (Whakawatea i te whenua). In a healing example provided by one healer, the land became the “patient” because it was the land that had become infested with malevolent spirits.

Once I’d located it [the area of land that needed to be cleansed], I went and got the things I needed which is a couple of bottles, empty of course. I went to the sea and I filled them up with sea water doing karakia. ... So I went down there and asked the tīpuna to surround the area. And then it started with the karakia, then went in and used water to form a boundary round the block I was doing, and then made a circle in the middle of the block with the water as a departure point for any entities that were going to be lifted off. And then ... did a karanga [call] to those entities telling them why we were here and what we were doing and then emptied both lots of water, sprinkled meself, done the job, jumped in me truck. Went back to the urupa [cemetery], thanked everybody for their assistance. (Toka)
In this example, the effect of the healing is not physical or emotional but takes place at a spiritual level, and both the healer and his tīpuna believe that a significant change has taken place by removal of the wairua, and the land has been healed.

There is support for a Māori connection with the land (Mark & Lyons, 2010), and a general recognition that good health for Aboriginal people relies on “an interconnecting system of land and spirit, body and mind” as noted by Beaton (cited in Elliott & Foster, 1995, p. 96). However, it is unknown whether healers of other Indigenous cultures send healing to the land or the dead, in a similar way as Māori healing, because little discussion has been found about this type of healing. However, this may simply be because Indigenous writers are not actively writing in the academy. For Māori, the land is a living entity, in the form of Papatuanuku, Earth Mother (Riley, 1994), and they understand all things, such as the land and plants, to have their own mauri or life essence (Henare, 2001). This may explain why RM healers believe it is possible to heal the land, in a way that is similar to healing a person.

Therefore, the scope of RM healing extends from being applicable to people, to also including the land. It also challenges the notion of healing as a mechanism that only assists living people to move from a state of illness to a state of health. In this case, the patient is the land and the healing involves clearing the land. It indicates that a patient of RM healing can be described as anything that requires healing.

Conclusions

This study set out to provide a broad overview of RM healing by exploring the underlying concepts of Māori healing, and to situate these concepts within Māori cultural values and beliefs. By working directly with RM healers, we have gained insight into their healing world and worldviews on RM healing concepts. The findings indicate that healers are actually mediators between their tīpuna and the patient, rather than a source of the healing. The healers also mediate relationships between people, both alive and dead, as well as with plants in order to facilitate, and contribute to, the healing of the patient. The role of healers as mediators in healing aligns with previous research showing Māori healers believe they are simply a vessel or a channel for the healing (Mark, 2008; McLeod, 1999).

The research findings show how RM is underpinned by a complex set of traditional cultural beliefs. Māori values and beliefs, including wairuatanga (spirituality), aroha (love), and connections with the whenua (land) and rongoā (herbal remedies), continue to be reinforced during Māori healing in the present day (Mark, 2008; McGowan, 2000; McLeod, 1999; Riley, 1994). Other traditional healing literature also discusses the importance of cultural values in healing, and in particular, the Indigenous focus on spirituality as well as the holistic concept of the mind, body, and spirit (Portman & Garrett, 2006; Struthers, Eschiti, & Patchell, 2004).

However, newer healing concepts can be gained from the unique findings on RM - of healing people who have already passed away and the land. Literature on the impacts of possession by malevolent spirits does exist, but it focuses on trance-like symptoms with lengthy and complicated rituals to free the patient (Tsintjilonis, 2006), which is dissimilar to Māori
examples of healing lost souls. The RM finding that it is possible to heal the dead challenges the idea that healing always leads to an improvement in physical, mental, or spiritual health for the patient. Instead, a new understanding is elicited from the research findings, that healing facilitates a process of change for patients.

Research has also been conducted to understand how relationships to the land contribute to the health of First Nations people in Canada (Wilson, 2003). The Māori cultural belief of the land representing Papatuanuku is shared with the Anishinabek, who also believe that the land is alive with spirits, and First Nations participants described communicating with the spirits of trees to deal with problems and/or conflict (Wilson, 2003). However, there was no indication of healing the land, and as noted earlier, this may simply be because other Indigenous authors have not written about it in the literature. This research on RM contributes to the traditional healing literature by challenging the focus of healing. The patient is described as anything that requires healing, such as those who have already passed away or the land.

As this research presents an initial and broad exploration into RM, each one of the research findings could be the subject of an entire research project, to elicit further detail and understanding of RM healing. Other insights into Māori healing could be gained by studying patients of rongoā, to explore the cultural values inherent in their healing experiences and healing outcomes. In addition, these findings on RM could be compared with other traditional healing systems to explore any further similarities or differences related to cultural values.

This research acknowledges the significance of connecting traditional values and beliefs with contemporary concepts of healing in modern practices of RM healing. As one healer said, “Rongoā Māori is our world” (Atawhai), and continuing to uphold cultural values in Indigenous healing while living in today’s modern society is not only culturally appropriate, but is vital to Indigenous health, healing, and wellbeing in a new and changing world.

References


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Impacts of Place and Social Spaces on Traditional Food Systems in Southwestern Ontario

Abstract
Processes of environmental dispossession have had dramatic consequences for dietary quality, cultural identity, and the integrity of traditional food systems (TFS) in many Indigenous populations. These transitions have not been documented among First Nation people in southwestern Ontario, and virtually no studies have investigated TFS in southern or urban regions of Canada. Nested within a larger community-centred project designed to better understand the social and spatial determinants of food choice and patterns of food security, the objective of this paper was to explore First Nation mothers’ knowledge about access, availability, and practices relating to traditional foods in the city of London, Ontario, and nearby First Nation reserves. In 2010, twenty-five women participated in semi-structured interviews that were audio recorded, transcribed, and analyzed with input from community partners. Our results centre on the women’s stories about access, preferences, knowledge, and sharing of traditional foods. Those living on a reserve relied more consistently on traditional foods, as proximity to land, family, and knowledge permitted improved access. Urban mothers faced transportation and economic barriers alongside knowledge loss related to the use and preparation of traditional foods. Overall our results demonstrate uneven geographic challenges for First Nation engagement in TFS, with urban mothers experiencing uniquely greater challenges than those residing on a reserve.

Keywords
Indigenous knowledge, traditional food systems, food sovereignty, environmental health, southwestern Ontario, geography

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Introduction

In the past few decades, research from various disciplines has described an interdependent relationship between Indigenous Peoples1 and their local ecosystems (Adelson, 2000; Burgess, Johnston, Bowman, & Whitehead, 2005; Ermine, Nilson, Sauchyn, Sauve, & Smith, 2005; Richmond & Ross, 2009). The health of the land and the health of the community are thought to be synonymous; health is nurtured through relationships to the physical environment, which provides the basis for cultures, kinship systems, and traditional ways of living to thrive. This important relationship is sanctified by a deep spiritual relatedness between people and their local environments, that which has been sustained for generations through Indigenous knowledge (IK). Indigenous knowledge refers to the cultural traditions, values, and belief systems that have enabled many generations of First Nation people in Canada to practise nourishing, healthful relationships with their natural and social environments (Cajete, 2000).

Traditional foods originate from the natural environment, either from farming or wild harvesting (Gagné et al., 2012; Kuhnlein, Erasmus, & Spigelski, 2009). Traditional foods are nutritious, local, and central to the physical health and well-being of Indigenous people. Their harvesting and consumption also hold important significance for the preservation of IK as they are housed within their own unique traditional food systems (TFS). A traditional food system refers to the sociocultural meanings, acquisition, processing techniques, use, composition, and nutritional consequences for the Indigenous Peoples using these foods (Kuhnlein & Receveur, 1996). The relationships that Indigenous Peoples have with their unique food systems and local ecosystems encourage practices, values, and traditions that perpetuate healthy Nations and territories.

Globally, TFS are being threatened by processes of environmental dispossession. These large-scale forces compromise Indigenous people’s access to the land and resources of their traditional environments (Richmond & Ross, 2009), generally leading toward decline in procurement of traditional foods and in the social, cultural, and economic benefits they provide. Across the globe, various processes of environmental dispossession have had the effect of limiting or reducing access to traditional foods among Indigenous populations, leading to the

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1 This paper is about Indigenous Peoples. The term Aboriginal encompasses First Nations, Inuit, and Métis people as formally recognized under the Constitution Act of Canada, 1982. These terms are used in accordance with terminology authors use when referring directly to their studies.
gradual replacement of these foods with marketed or pre-manufactured products. This transition has had dramatic consequences for dietary quality and cultural identity, along with the health and maintenance of TFS (Cidro, Adekunle, Peters, & Martens, 2015; Egeland, Williamson-Bathory, Johnson-Down, & Sobol, 2011; Johnson-Down & Egeland, 2010). In Canada, only about a quarter of First Nation adults consume wild meat from their local environments and even fewer (18.6%) include wild plants and berries as part of their diets (FNIGC, 2012). The base of research investigating dietary practices among First Nation communities in Canada has historically tended to focus almost exclusively on intake, with considerably less attention given to understanding how knowledge, access to Indigenous knowledge, and knowledge loss about traditional food systems may impact local food security (Campbell, Diamant, Macpherson, & Halladay, 1997) or the food sovereignty of Nations. Food sovereignty expands the focus of food security from food cost, access, and availability toward understanding the ways in which power relations and inequality undermine production, distribution, and consumption patterns (Kuhnlein, Receveur, & Chan, 2001; Power, 2008).

**Food System Environments**

While a broad body of research details how processes of environmental dispossession are at the root of cultural change and environmental contamination among Inuit and other northern and circumpolar peoples (Kuhnlein et al., 2001; Organ, Castleden, Furgal, Sheldon, & Hart, 2014; Willows, 2005), there is a gap in published research exploring the mechanisms that link processes of environmental dispossession with TFS among populations in southern regions of Canada (Kirkpatrick & Tarasuk, 2008; Mundel & Chapman, 2010; Stroink & Nelson, 2009). Even though the origins of these concerns may reflect global food trends, such as the overall environmental health of TFS, the mechanisms or determinants by which access to traditional foods has been reduced are different. For example, the impacts of colonialism and forced assimilation associated with urbanization patterns have eroded the relationships that have existed between Indigenous Peoples and their local ecosystems. Not only have these influences reduced physical access to the foods available in the environment (Organ et al., 2014), but they have also stressed relationships necessary to maintain social structures that underpin the transmission of IK.

Processes of dietary change, access to traditional foods, and Indigenous knowledge among southern First Nation communities have received very little research attention. The small base of research with southern and urban First Nation people indicates real and important challenges related to the maintenance of traditional food systems (Gendron, Hancherow, & Norton, 2016; Richmond et al., 2017). As current demographic trends detail, southern First Nation populations are becoming not only more urban but also overrepresented by youth and children. There is a need to do food systems research that will lend itself to informing policies that can both respond to and address the health, social, and cultural needs of these diverse southern First Nation populations as these processes are representing new geographies. Few studies have investigated TFS in southern or urban regions. Most studies on traditional food
patterns have taken place in northern communities (Gaudin, Receveur, Walz, Girard, & Potvin, 2014; Lambden, Receveur, Marshall, & Kuhnlein, 2006; Receveur, Boulay, & Kuhnlein, 1997; Sheehy, Kolahdooz, Roache, & Sharma, 2015). Groups living in more populated regions of Canada have not been investigated as extensively, although low incomes, high unemployment, and loss of traditional food environments have been similarly found to contribute to food insecurity among southern groups (Neufeld, 2003; Sinclair, 1997; Willows, Veugelers, Raine, & Kuhle, 2011).

Population groups such as women, lone-parent families, and Indigenous people have previously been identified as being most likely to be food insecure in Canada (Willows, Veugelers, Raine, & Kuhle, 2009). In Ontario, 29% of First Nation households on reserves experience food insecurity (Chan et al., 2014). An examination of other influences on food choice is severely lacking from the literature. Factors that determine foods selected are complex and not guided exclusively by affordability or either individual or household characteristics. A range of unique influences such as education, politics, technology, cultural preferences, and individual biological need shape availability and ultimately food choice. In an Indigenous context many of these determinants relate to the social, cultural, historical, environmental, and economic marginalization of Nations and communities.

This paper explores the challenges, meanings, and desires of the modern traditional food system among First Nation women in southwestern Ontario, Canada. Theoretically framed by the concept of environmental dispossession, we qualitatively examined traditional food access, knowledge, sharing practices, and preferences among First Nation women in the city of London, Ontario, and at two nearby First Nation reserves.

**Methods**

**Research Process**

This research project resulted from a research partnership between the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and researchers from the Indigenous Health Lab at Western University. SOAHAC is one of 10 Aboriginal Health Access Centres in Ontario. It is funded by the Aboriginal Healing and Wellness Strategy to provide health care services to Aboriginal people in London and at its satellite office on the Chippewas of the Thames First Nation. SOAHAC provides holistic health services and promotes traditional and Western health practices to approximately 1,000 clients at its London office and another 1,000 clients at the Chippewa office (SOAHAC, 2016).

The SOAHAC Food Choice Study began in 2008 as a two-phase, community-based project collaboratively designed to examine the social and spatial processes underlying dietary practices, food security, and sources of food among urban and reserve-based First Nation households in southwestern Ontario. The study took a community-based approach that heavily involved SOAHAC staff and community members in its design, implementation, analysis, and dissemination of results. Dietitians and other health care providers had expressed their
frustrations with generic nutrition research and education approaches (e.g., 24-hour recall); they expressed a strong desire for research that would enable meaningful community input around the more systemic forces that underlie food choice, such as food insecurity. The objective of the Food Choice Study was to provide culturally and socially relevant data for their programming efforts. This approach was adopted to ensure that research with First Nation communities promotes capacity-building and knowledge formation that benefits all research partners involved (Castellano, 2004; CIHR, 2013) and was influenced by the principles of OCAP (ownership, control, access, possession).

To initiate the research and gain community support for the project, two large community feasts were held in September 2008 at each of the selected SOAHAC locations. The first phase of the research was quantitative in nature and developed around the Food Choice Survey instrument. The survey was pre-tested and self-administered to 229 participants, including 99 on-reserve and 130 urban participants. Descriptive statistics were generated to establish dietary patterns, food sources, and levels of food security (results reported elsewhere: Richmond, Steckley, et al., 2017). These patterns were described according to income, age, gender, household type, and geographic location. Results indicated an overrepresentation of food insecurity among First Nation women with young children, which directed the development of the second qualitative phase in 2010 to examine in more detail determinants of food choice among mothers with young children.

Interview questions were therefore shaped by the results of the quantitative interviews, designed in collaboration with SOAHAC staff and piloted prior to use. Study objectives included (a) investigating current knowledge surrounding access, availability, and practices relating to traditional food among urban and on-reserve First Nation families, and (b) describing present-day urban and rural food environments in this region of southwestern Ontario. This paper focuses on the comparison of traditional food practices among First Nation families living in London, Ontario, with those of nearby reserve communities that access SOAHAC services.

Prior to data collection the study received ethical approval by SOAHAC’s board of directors, as well as the university’s Non-Medical Research Ethics Board. Women were fully informed of the study prior to giving consent, and their privacy was protected. Each of the mothers also received a $50 food voucher for a local grocery store for their time.

Participant Description

A sample of 25 mothers was recruited, with 14 living in London at the time of their interview, and 11 from First Nation communities within 30 km of the urban centre. The city of London, Ontario, has a population of 492,200, of which approximately 6,000 self-identify as First Nation, Métis, or Inuit (Statistics Canada, 2013).

Demographic data for all participants appears in Table 1. Study participants living in London ranged in age from 24 to 55, with a median age of 34 years. Those living in reserve

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2 OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC; www.fnigc.ca).
communities were from 23-58, with a mean of 36 years. More women in the city were single (10 versus 4 married). Only 5 living on a reserve were single, 4 married and 2 common-law. On average women in the city had 2.4 children; slightly less than 2.5 on the reserve. Pseudonyms have been used for the participants. Names beginning with “R” and “C” refer to mothers from reserve and city (urban) locations, respectively.

Table 1

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Residence</th>
<th>Age</th>
<th>Marital status</th>
<th>No. children</th>
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<td>3</td>
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<td>Carol</td>
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<td>33</td>
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<td>1</td>
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<tr>
<td>Carrie</td>
<td>London</td>
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<td>2</td>
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<tr>
<td>Cathy</td>
<td>London</td>
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<td>Single</td>
<td>3</td>
</tr>
<tr>
<td>Cecily</td>
<td>London</td>
<td>25</td>
<td>Single</td>
<td>2</td>
</tr>
<tr>
<td>Celine</td>
<td>London</td>
<td>39</td>
<td>Single</td>
<td>2</td>
</tr>
<tr>
<td>Chantal</td>
<td>London</td>
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<td>Single</td>
<td>3</td>
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<tr>
<td>Charlene</td>
<td>London</td>
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<td>Cheryl</td>
<td>London</td>
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<td>Collette</td>
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<td>Cora</td>
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<td>1</td>
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<td>Corine</td>
<td>London</td>
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<td>4</td>
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<td>Ruth</td>
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<td>24</td>
<td>Common-law</td>
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</table>

Data Analysis

Interviews from the second phase of the Food Choice Study were tape recorded with each participant’s consent and transcribed verbatim. Organization and coding of the transcribed data were conducted using QSR International’s NVivo 9 computer software for the primary thematic
analysis of the interviews, focusing on common themes and patterns of food choice among young families. This initial analysis specifically examined food preferences as well as environmental factors influencing food choice, such as family type, place of residence, food access, and perceived barriers (results reported elsewhere: Richmond, Neufeld, et al., 2017). These results were subsequently discussed and refined into larger categories with SOAHAC staff prior to conducting final focus groups with the interviewees. Willing participants from the second phase of the study were invited back to the SOAHAC sites to participate in focus groups or sharing circles, where these initial results were presented and discussed to provide a means of member checking, ensuring that participants’ experiences were being interpreted in a meaningful way.

Further analysis of these qualitative interviews began in 2014, with a focus on traditional food access, knowledge, and preferences among First Nation women and their families living on and off reserves. Themes and categories identified from the interviews were coded and analyzed using QSR International’s NVivo 9 software. Analysis involved browsing, searching, coding, and categorizing the interview text using a constant comparative method of data analysis associated with grounded theory (Strauss & Corbin, 1998). The software was also used to search and further interpret the interview text through the creation of models and memos (Richards, 2005). Thematic analysis was also employed along with coding and matrix queries to assist in further identifying relationships between categories, as well as place of residence and other sociodemographic data (Bazeley, 2007). Initial results and themes were shared with SOAHAC staff, prior to the development of life history interviews that were conducted with female Elders representing the same communities in 2015 (Neufeld, Richmond, & Southwest Ontario Aboriginal Health Access Centre, 2017).

Results

Interviews with women living either on a reserve or in the city of London included specific questions related to their (a) use of, (b) access to, and (c) knowledge of traditional foods. Mothers were asked about personal meanings they associated with traditional foods, the frequency of family meals incorporating traditional foods, as well as specific challenges related to accessing traditional foods in urban and reserve settings. Participants from both groups spoke about access to and preferences, knowledge, health properties, and sharing of traditional foods. Access issues were the most common theme discussed by both groups of women. Each interviewee spoke about the ways they are challenged by reduced access to traditional foods. All but three women living on a reserve have regular access to traditional foods (e.g., deer meat, fish, corn soup, wild rice, berries), compared to only four of the 14 participants living in London who reported having inconsistent access to these foods. The range of women’s narratives will be presented in the following sections, framed according to primary themes and location. Quotes have been edited slightly to improve readability.
Knowledge

Knowledge limitations around the preparation of traditional foods, and around hunting and harvesting practices, were frequently discussed by all participants. Although more women from the city talked about these challenges, both groups expressed their frustrations with the preparation of many traditional foods. Chantal explained:

*It’s harder, especially when on the reserve you’re closer to family. And if someone was cooking or we’re going to make stuff, we could do it together. But in the city, we’re all scattered around and we don’t get to see each other.*

Homemade breads and soups were particularly challenging for mothers to prepare on their own. Those on a reserve described the traditional preparation of corn soup with hardwood ashes to be especially complex and time-consuming. Many, like Raven, relied on family members:

*I make fry bread once in a while, but corn soup, I don’t know how to make it so if we have it it’s either pay for it or … if my mom makes it she’ll always make a lot so we’ll get some that way.*

Both groups of women recommended that it would be beneficial to offer cooking classes to learn traditional techniques or create a method of recipe sharing to make traditional food knowledge more accessible. Carla suggested:

*Maybe there could be more classes on how to cook more traditional foods, or even just—like I don’t have a recipe for anything traditional. My mom gave me recipes for soups and stews and things like that, but I wouldn’t know how to cook corn soup. No one ever taught me that. So it’s not in my mind how to cook it. And I don’t think a lot of people know.*

Several women from the urban group discussed their lack of general knowledge related to traditional foods and other cultural traditions around Indigenous foods. One participant, Carrie, was not familiar with the term *traditional foods* at the start of her interview until she was given examples of foods she recognized, such as fry bread and corn bread. Cindy and Collette had difficulty remembering the story of the Three Sisters (corns, beans, and squash) that were traditionally planted and cooked together in a soup with the same name. Cindy said,

*I remember there was a story. I can’t remember what it was. Like I was taught it—I went to a Native school. I can’t remember what it was. There [were] three main foods and I can only remember corn. There was two other ones and I can’t remember.*

Three other urban participants talked about the challenges related to knowing where to find ingredients to prepare traditional foods such as corn soup. Charlene commented, “I don’t really know where to get, like, the [white] corn and stuff and how to make it myself. I always rely on
other people that make it.” Cathy explained that having to find the ingredients is particularly difficult: “If you weren’t raised that way, then it’s a chore to find your way back to doing what should be done.” Carla said she would like “more knowledge so I can cook whatever I wanted to cook without having to look it up, or going around and asking everybody else how to do it.” Cindy made reference to similar barriers negatively impacting traditional knowledge transfer due to families becoming increasingly “urbanized,” along with “[not] knowing your Elders, because they’re the ones that pass down all this tradition.” Cindy was aware of the legacy of residential schools and their structural impacts on knowledge transfer from Elders to younger generations. She empathized with her sister and the challenges she faces, not having access to transportation to travel to her home community and speak with her Elders and learn how to prepare traditional foods. As she said, “My sister, she doesn’t even make bread.” Cindy made the connection that her sister

didn’t go to the same schools I did, because she didn’t grow up in my household. She’s about ten years older than me. I think my mom might have had more problems back then, than she did when I was growing up. So maybe that has something to do with it too.

A smaller number of women living on a reserve talked about the disappearance of traditional harvesting and hunting knowledge. Rita had a lot to say on the subject of hunting and the shifting of traditional roles related to food procurement:

We lost a lot of our hunters—a lot of our hunting ways. There’s very few that go hunting, like normal hunting. Like we have pheasant, we have wild turkeys around here, but you don’t hear of hardly anybody getting any of that stuff. When I was a kid, everybody ate everything.

She went on to suggest:

Probably if we had some kinda life skills that taught everybody how to hunt again that would help. I’ve gone hunting once when I was younger. We were hunting pheasants, but my husband, I don’t think, has ever hunt[ed] ... So I think if we had some kinda traditional teachings on what a hunter is. Something like that to help the people empower—get back to something like that again, definitely, because a lot of people don’t even know how to load a gun. Like, I don’t know how to load a gun. I’d like to hunt. Nobody has the skills like that anymore ... very few.

Sharing

Compared to those living on a reserve, substantially fewer urban-based participants talked about the concept of sharing traditional foods and knowledge within family and the wider community. However, both groups did refer to sharing practices within their immediate and extended families. They also talked about the importance of sharing resources, such as food,
within their communities. Nearly half of the urban interviewees provided examples of the ways they share traditional foods within their families. Cindy described a common practice she experienced every time she returned home to her community:

> When we go to my grandma’s house, she always gives us food. That’s one thing that Native people do is they give food. It’s like one of those things. I don’t know if everybody else does that. I know my grandma and my mom always have something.

Carol shared her experience: “Last week, my mother had a party and she made corn soup. So we had corn soup and I brought some home. And we had a big thing of it and we had it for supper.” She also talked about the importance of having a hunter in the family and how her son’s father provides for them “because his dad is a fisherman and a hunter, he gets ducks and deer and stuff like that. We have pickerel because I don’t have to pay for it. So I have a lot of fish in my fridge.”

Comparatively, nearly three quarters of the on-reserve interviewees gave examples of the ways traditional foods, mainly wild meats, were shared within their families and communities. Several of the reserve-based respondents highlighted the ways in which the city can limit traditional contributions from extended family and others. Roberta empathized, “Every time I turn around and go to somebody’s house they always got something going. If it ain’t corn soup, they’ve got fried bread going or something. You wouldn’t find it in London as you would down here.” Rae, however, thought that circumstances had changed in her community from the time she was younger:

> I remember my grandmother used to have these [working] bees and everybody come together and we’d have all these wild foods. They used to give away for pies for the people that have nothing. All the women would get together and cook up everything. But you never ever see that no more.

Rae was concerned that the value of sharing was not being practised in the same ways today as it had been in the past. She said:

> Nowadays, people just go out there and take our venison, the deer—their deer—they just go out there and abuse it. Like they shoot it, they skin it; they take it and sell it instead of just taking what they need and giving it to the people. You never seen anybody no more helping other people.

She went on to suggest:

> They should go back into that helping. Neighbours used to help neighbours and walk for miles, and give somebody that didn’t have something, they’d give it to
them. And you don’t, never see that no more—ever. They give you something, you have to buy it.

Mothers from both urban and reserve locations also talked about local limitations on the transference of traditional food teachings and sharing practices reflecting IK. These connections to traditional foods were discussed briefly by a handful of participants. Cecily referred to the transfer of energy she experiences with deer meat: “They’re strong and they exercise those animals. I think about that and if I’m eating that, that’s how I’m gonna be.” Rita also talked about the pride she felt in the teachings she had as a child to lead a sustainable lifestyle and expressed the desire to transfer or share that knowledge and “teach my kids to hunt, to garden, to live.”

Preferences

Most interviewees, from both urban and reserve settings, talked at length about specific traditional foods they and their families most enjoyed, in terms of taste perceptions, celebratory associations, and familiarity, as well as community or cultural ties that these foods fostered. While on-reserve women discussed these preferences more frequently during their interviews, both sets of women talked about the cooking techniques they used when preparing wild meat. Roberta complained, “I’ll cook everything else, but other than venison. I just can’t stand the smell!” Robin said, “If you can get that gamey taste out of there, I’ll eat it!” For those who grew up in the city or were bringing up their children in the city, there was a demonstrated lack of familiarity, for instance, with wild meats such as deer. Cathy explained, “There’s a lot of traditional Native foods that are made that just weren’t a part of my staple of food growing up, so it’s kind of not very tasty either.” Interestingly, quite a few of the respondents described cooking techniques they used to mask the taste of wild meat and present it to family members as store-bought beef, which seems to reflect a paradox to maintain these connections with wild foods even though the focus is on their preparation and not their consumption. Raven described her approach:

*I think it depends on how you cook it because I know when I—at first I did not like it. And then I seen someone else the way they cooked it and I didn’t even know that’s what it was. So when I cook it I don’t tell my kids until after they eat it and they don’t know the difference from that or a roast because I’ll cook it like if I have a roast—it just all depends on the way you cook it. I have it in water with salt and sit like that for a day. Then I put this marinating sauce on it. Then I throw it in a slow cooker like that. And they think it’s a roast beef!*

Personal motivations to prepare traditional foods like deer meat for their families in London frequently reflected children’s preferences. Over 70% were single parents living on fixed incomes in the city. They did not want to waste precious funds or time on food their children did not want to eat. Celine described the frequency of traditional foods she prepared at
home as “not something that happens all the time because my children won’t eat them.” She went on to say, “because it takes a lot of work to cook them and make them and everything like that. It’s something I always buy. I don’t make corn soup and I won’t make fry bread.” Participants in the city tended to associate traditional foods with celebratory occasions involving extended family, fostering a sense of belonging and cultural identity. When asked why it was important to have traditional foods at family gatherings, Celine responded,

Well, it’s a celebration. We all enjoy it, my extended family. So it’s like a delicacy. So I think it’s important. It’s part of who I am. I grew up eating corn soup and having it at my grandma’s and we always had fish [too]. And so it’s just part of who I am.

On-reserve participants talked about traditional foods in the context of special occasions and discussed the environmental and health benefits of consuming a variety of “foods that come out of the ground.” Preferences for certain traditional foods were not necessarily associated with special events and extended family for those in the city. Ruth talked about these foods as “things that aren’t processed, don’t have any added salt.” Making these foods regularly and having access to wild sources of meats and plants were not necessarily considered out of the ordinary. As Rena said, “We pretty much have it—it’s not something that’s a big, special traditional night thing. We can get venison meat if we ever needed it. We can get the fish if we ever need it.” Robin described all the wild meats that were available in her community and other types that she had previously prepared and preferred: “I’ve tried venison, goose, I think it was a moose. The wild turkeys that you see, I’ve tried that too.” Some of these less common wild meats available locally were often described, along with variations in the preparation of corn soup and homemade breads. Gunjen, or oven bread, for example, was a local favourite compared to more familiar forms of fry bread or bannock. Ruth talked about her husband and daughter loving it, but since she was raised in a more northern community, “if it came to bannock and gunjen, I would definitely take bannock!”

Access

Both on- and off-reserve interviewees reported their access to traditional foods to be determined by environmental safety concerns, seasonal availability, and the time and costs associated with procuring traditional foods. Mothers from urban and reserve locations were worried about the safety of consuming fish and other animals from the local environment, in particular the Thames River, which runs through the city of London and the two nearby First Nation communities. As Robin cautioned, “You don’t know what the animals are consuming. Same with the river, you don’t know what’s in that river anymore, so you’re almost scared to eat the fish.” As Cecily expressed: “There’s so much pollution in the water and on the earth and in the air. You gotta really think about it, is it really healthy for me to be eating so much of this natural source of food that our people used to live on?” Seasonal availability of certain items like berries and fish was discussed as a barrier that limited the variety of traditional foods available
during the winter months. Time constraints also were expressed by many women with regard to both the preparation efforts required for corn soup and corn bread, as well as the added time spent travelling to access certain ingredients. Even though she lived outside of the city, Ruth complained that “sometimes it is easier to go to the grocery store and get it when it’s already packed than going to find someone who has the [wild] meat I want.”

Transportation to and from their home communities was frequently mentioned by urban respondents as time consuming and costly, yet necessary to access wild meats, fish, and other ingredients used to prepare traditional foods. As many live at a distance from family, accessing traditional foods means increased transportation costs to obtain wild foods harvested on reserves, or to participate in extended family meals. Chantal complained that “it’s hard to have the money when you want to find the foods. Sometimes you hear about it in the city, you want to go but don’t have the money to do it.” Prepared soups, breads, and other items for some London residents may be available only during celebratory events such as powwows or sold commercially on reserves.

Several of the reserve-based women suggested that it can be expensive to purchase prepared foods such as corn bread, fish, and other wild meats if you don’t know a hunter or someone willing to share local wild foods. As a grandmother living on a limited income with her young grandson, Rae complained about the price of rabbit and fish available commercially. She said, “When you go to buy fish it’s very expensive. I’m very lucky. Sometimes my cousin from Kettle Point, she brings me fish and just gives it to me, but she’s like me. She can’t get around too well.” Due to environmental concerns, fish and other wild meats were also thought by many to be safer and cheaper, and therefore more accessible, in the near north, compared to southwestern Ontario. As Rita said, “The wild fish and game, it’s cheaper up there. Just that you gotta go up there and get it, or ship it down here.” The costs associated with travelling and purchasing equipment to access other desirable traditional foods such as wild rice and moose meat further north were viewed as significant barriers to access.

**Discussion**

This research sought to explore the impacts of place on traditional food systems in southwestern Ontario, using environmental dispossession as the theoretical framework from which to understand the linkages between TFS and IK in this context. Analysis of interviews with on-reserve and urban First Nation women reveals considerable spatial differences in access patterns and knowledge. Those living on a reserve relied more consistently on foods such as wild meats, fish, corn soup, wild rice, and berries compared to those in London. Many described daily as well as weekly preparation and consumption of these foods. Urban mothers faced transportation and economic barriers associated with accessing ingredients or participating in family events back in their home communities, while those on reserves talked about the benefits of living in a tight-knit community with family members and friends who hunted and fished on a regular basis. Women’s worries about environmental safety of wild foods prevented consistent
access among both urban and reserve-based women, as did the seasonal availability of items such as fresh berries or fish. These findings were consistent with the quantitative results of the Food Choice Study (Richmond, Steckley, et al., 2017). Both on-reserve and urban respondents reported consuming fewer traditional foods than they would like as a result of access barriers such as time and knowledge. Spatial differences in food sources were also noted, with urban families indicating greater limitations in accessing traditional foods than those living on a reserve.

Access to knowledge, land-based activities, contact with Elders, and cultural capacity around food is also integral to the health and maintenance of TFS (Richmond, Neufeld, et al., 2017). Traditional food systems are also highly influenced by resource availability and the physical environment (Kuhnlein et al., 2001; Waldram, 1985; Wein, Henderson Sabry, & Evers, 1991). Previous studies examining traditional food access and availability have often taken place in remote regions where environmental safety issues associated with traditional foods such as wild meats and fish have been viewed with concern, particularly in northern communities where contaminants have accumulated up the food chain in many species (Furgal & Seguin, 2006; Kuhnlein & Chan, 2000; Receveur et al., 1997; Tsuji et al., 2005; Waldram, 1985; Wein et al., 1991). Comparatively, in southern Canada, few studies have reported on environmentally contaminated locally harvested foods (Abonyi, 2001; Bruyere & Garro, 2000; Chan, Trifonopoulos, Ing, Receveur, & Johnson, 1999; Garro, 1994; Lang, 1989), or their decreased access due to environmental modification, such as urban development and the displacement of Indigenous species (Doolan, 1991; Hlimi, Skinner, Hanning, Martin, & Tsuji, 2012; O’Neil, Reading, & Leader, 1998; Turner & Turner, 2008; Wheatley & Paradis, 1997).

The concept of sharing food was significant among both urban and reserve-based respondents, but the practice seemed to be more highly valued in the urban centre where traditional foods are less prevalent. Sharing practices have been much more widely documented in the literature, even though only 27.9% of First Nation adults in Canada report sharing traditional foods on a yearly basis (FNIGC, 2012). The majority of these studies have found that community sharing occurs as an adaptation to food shortages (Chan et al., 2006; Ford, Berrang-Ford, & Paterson, 2011; Robidoux, Haman, & Sethna, 2009; Skinner, Hanning, Desjardins, & Tsuji, 2013). Other investigations in the north have listed the following barriers to community sharing: increasing hunting costs, no hunter in the household, and environmental change negatively impacting yields (Beaumier & Ford, 2010; Ford et al., 2011; Socha, Zahaf, Chambers, Abraham, & Fiddler, 2012). Only a handful of authors have written about the sharing of traditional foods in a southern or urban context. One study set in a First Nation high school described food sharing happening as a result of cultural programs held where these foods were regularly served (Kerpan, Humbert, & Henry, 2015). Out in the community, hunters living in and outside of the city also distributed wild meat to those families in need. According to the participants of the current study, these community-based food sharing networks appear to be disappearing as they are replaced with more Westernized forms of distribution with individualized economic benefits. A Vancouver-based study parallels some of the findings in our
study, particularly those related to the unique challenges in accessing traditional foods in an urban setting. The Vancouver participants stated that traditional foods are commonly shared through community networks, but due to distance and disconnection, these practices are limited when living in the city (Elliott, Jayatilaka, Brown, Varley, & Corbett, 2012).

The frequency of traditional food consumption is often linked with taste appreciation (Kuhnlein, 1992), and this was certainly the case in our study, where nearly all participants talked about the properties of traditional foods as well as their preferences. They shared cooking techniques used to mask the stronger flavour of wild meats, especially when serving them to their children. Women also associated other traditional foods such as fry bread and corn soup with family events and celebrations. Those living in London tended to prepare these items less often because their children would not eat them and the food would go to waste. Although preferences appear to be shifting away from traditional foods, fondness for traditional foods tends to be associated with increased age, exposure, and positive experiences (Bruner & Chad, 2013; Kerpan et al., 2015; Kuhnlein et al., 2009), which seemed meaningful for several women in this study who continued to prepare wild meat even though they did not like the flavour. Younger community members often report a preference for store-bought foods (Bruner & Chad, 2013), as was also mentioned by participants with young children in this study, along with women who did not have the same familial connections with these foods. Research in rural and urban Alberta is, however, demonstrating that family and school can positively influence traditional food experiences (Kerpan et al., 2015; Pigford, Willows, Holt, Newton, & Ball, 2012). Increased exposure to these foods through school programs, cultural activities, and family events has been shown to increase both the frequency of consumption and taste preferences among urban youth. On reserves, knowledge gained from Elders and family members most consistently informed children’s food preferences and health beliefs (Pigford et al., 2012).

Loss of knowledge related to the decreased use of traditional foods was demonstrated most consistently in this study by mothers living in London. They were often challenged by the time and teaching necessary to prepare certain recipes like corn soup. In the city, for example, many of the participants indicated they did not have consistent access to Elders and extended family. Several expressed their desire for connection to both their culture and the past. It was also difficult to locate a consistent supply of locally sourced animals and fish when immediate family members no longer possessed the hunting skills or knowledge to prepare wild meats. Women living on reserves talked about the importance of sharing traditional foods and knowledge. A few were concerned that community-sharing practices were changing, with younger hunters selling wild meat instead of distributing it without cost as had been the practice in the past.

It is well known that harvesting and hunting practices were irreparably impacted by assimilative actions taken to sever communities from their traditional lands and knowledge systems (Degagné, 2007; Elias et al., 2012; Raschke & Cheema, 2008; Richmond & Ross, 2009). In our study context of southwestern Ontario, results demonstrate the dramatic impact processes of environmental dispossession have had on TFS and IK expression, especially for First Nation
women in London. Indigenous women’s identities are continuing to evolve in new environments. However, urban locations have created significantly greater challenges to fully engage in TFS as a result of their physical and social distance from their communities. Their geography has presented a number of practical limitations to practising TFS in meaningful ways, but so too are they limited by their relative social and cultural exclusion from their home communities. At the root of many of these women’s stories of urbanization lie uneasy truths about the politics of identity and Bill C-31, that clause in the Indian Act that has separated women from their communities and children from their families (Bourassa, McKay-McNabb, & Hampton, 2004; Richmond & Cook, 2016). Life history interviews with female Elders representing the same communities in southwestern Ontario further illustrate these intergenerational impacts that have disconnected First Nation women, in particular those living in urban centres, from the land (Neufeld et al., 2017). Shifting from subsistence farming on reserves to wage economy pursuits in the nearby United States, for example, divided extended families from each other and the land.

Conclusions

The SOAHAC Food Choice Study is one of the first in southwestern Ontario to qualitatively examine patterns of traditional food use among First Nation people living in reserve and urban settings. Interviews with First Nation women demonstrate considerable spatial differences in access patterns and knowledge. With approximately 60% of First Nation people now living off reserves in Canada (Statistics Canada, 2013), a more comprehensive understanding of the unique environments impacting traditional food systems in an urban context is essential. Continued community-engaged research aimed at increasing control over local food systems in these under-researched places and spaces is recommended. Future research on the sustainability of food environments and TFS needs, however, to shift from a focus on food security towards the concept of food sovereignty (Grey & Patel, 2015). In the Indigenous context, food sovereignty encompasses the ability to acquire foods in socially acceptable ways, such as through traditional practices (FAO, 1996; Schuster, Wein, Dickson, & Chan, 2011; Willows et al., 2009) that may encompass IK. An Indigenous food sovereignty framework explicitly connects the health properties of food with the health of the environment and identifies a history of social injustice as having radically reduced Indigenous food sovereignty in nations such as Canada (Morrison, 2011). It addresses aspirations for collective well-being, along with acknowledging land rights and cultural integrity. Indigenous food sovereignty also considers gender equity and adequate nutrition, and it addresses structural racism and a restructuring of sociopolitical processes (Cidro et al., 2015).

The emerging literature on the Indigenous food movement identifies community involvement, family-centred education about food, and a re-established relationship with the land as essential to the restoration of traditional food systems (Kuhnlein et al., 2009). Progress has been made in the resurrection of traditional food systems. In northern Minnesota the community of White Earth is focused on achieving the localized harvesting of traditional foods. Food-related projects such as gardening and maple sugaring also have an impact on the physical health and
cultural connectedness of community members (LaDuke, 2005). Another project in Saskatchewan highlights the importance of Elders and community members in exploring and revitalizing the use of Indigenous foods by passing on knowledge through workshops on the identification, harvesting, processing, and preparation of Indigenous foods and medicines (Gendron et al., 2016).

Community involvement and family-centred education about food as well as re-establishing a relationship with it and the land are necessary to overcome the present-day environments that continue to act as barriers towards a collective vision involving the sharing of resources, increased access, knowledge, and positive associations with traditional foods. The dimensions that constitute TFS can contribute toward the holistic health of individuals and communities (Kuhnlein et al., 2009). Traditional food systems are complex and holistic. These foods are valued from a physical health perspective, and the activities involved in their acquisition and distribution allow for the practice of cultural values, such as sharing and cooperation (Earle, 2011). There is urgency in promoting the sharing of practices and increasing knowledge capacity around traditional foods through increased social support within both families and the larger community of women living in urban environments. Elevating traditional foods and TFS as pathways towards self-determination also reinforces both dietary and biocultural diversity (Johns & Sthapit, 2004). Diversity in both forms thereby improves health and continues to build resilience.

References


The Effect of a 12-Week Exercise and Lifestyle Management Programme on Cardiac Risk Reduction: A Pilot Using a Kaupapa Māori Philosophy

Abstract

Introduction: Cardiovascular disease remains the leading cause of premature death and disability for all New Zealanders. Māori, the Indigenous people of New Zealand, are disproportionately affected. The New Zealand Māori Health Strategy recognises that “health and wellbeing are influenced and affected by the ‘collective’ … and the importance of working with people in their social contexts, not just with their physical symptoms” (Ministry of Health, 2002, p. 1). In a Māori worldview, a holistic approach to health is innate. Objectives: This project piloted a kaupapa Māori approach within an existing 12-week clinical exercise and lifestyle management programme. The aims of the study were to determine the effectiveness of a kaupapa Māori 12-week exercise and lifestyle management programme on parameters of cardiac risk and quality of life. Methods: 12 Māori participants attended, 3 times per week over a 12-week period, for monitored, supervised, and individualised exercise. Participants performed a progressive aerobic-only programme for 6 weeks and then a combined aerobic and resistance training programme from weeks 7 through 12. Education sessions were chosen by participants. Results: There was a statistically significant improvement in waist circumference (−3.7 cm; \(p = 0.05\)), hip circumference (−4.6 cm; \(p = 0.03\)), systolic blood pressure (−22 mm Hg; \(p = 0.01\)), and HDL cholesterol (0.22 mmol/L; \(p = 0.01\)). In addition, physical (\(p = 0.05\)) and overall (\(p = 0.03\)) quality of life improved. Conclusion: A kaupapa Māori approach within a structured lifestyle management programme modifies cardiac risk parameters in Māori.

Keywords
Cardiovascular disease, kaupapa Māori, exercise, interface space

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Introduction

Cardiovascular disease (CVD) remains the leading cause of premature death and disability for all New Zealanders, accounting for 30% of deaths annually (Ministry of Health, 2010). Māori are disproportionately affected by CVD, which is the principal reason for the difference in life expectancy between Māori and non-Māori (Chan et al., 2008; Wells, Broad, & Jackson, 2006). Life expectancy at birth is 76.5 years for Māori women and 72.8 years for Māori men, compared with 83.7 years for non-Māori women and 80.2 years for non-Māori men (Ministry of Health, 2014). Innovative approaches, focusing on prevention and management of CVD and using principles associated with a Māori worldview, are required to improve CVD outcomes and life expectancy for Māori.

Kaupapa Māori is an accepted framework for health research in Aotearoa/New Zealand and is underpinned by critical theory. Māori beliefs and values are placed at the centre of the research process and findings are applied based on Māori views of the world. Māori health is holistic, considering more than just the physical aspects of a person, and a number of Māori health models exist (Durie, 1998; Durie, 1999; Pere & Nicholus, 1997). The most commonly referenced model is Mason Durie’s (1998) Whare Tapa Whā. The model is symbolised as a wharenui (meeting house) with the four walls of the whare (house) representing the four dimensions of Māori health: Taha hinengaro (mental health), Taha wairua (spiritual health), Taha whānau (health of the family), and Taha tinana (physical health). Each wall is essential for the strength and symmetry of the whare, and as such each dimension of health must be balanced for an individual to be well. In this regard, the New Zealand Māori Health Strategy, He Korowai Oranga (Ministry of Health, 2002) recognises that “health and wellbeing are influenced and affected by the ‘collective’ as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms” (p. 1).

Exercise as an intervention in disease prevention and management is well accepted, and evidence to support its use for CVD continues to accumulate (American College of Sports Medicine, 2014). Cardiorespiratory fitness has an inverse relationship with premature death from all causes, but especially from CVD (Kodama et al., 2009; Sesso, Paffenbarger, & Lee, 2000), and high levels of fitness are associated with higher habitual levels of physical activity and exercise (Wang et al., 2010). Exercise is also known for its ability to reduce CVD risk through changing risk factors, including reductions in systolic and diastolic blood pressure, increased high-density lipoprotein cholesterol (HDL-C), decreased triglycerides, reduced total body fat including abdominal adiposity, reduced insulin need, improved glucose tolerance, and reduced platelet adhesiveness and aggregation (Kesaniemi et al., 2001; Nelson et al., 2007). Poor nutrition has a definite role in the development of CVD, and therefore evidence-based guidelines
highlight the importance of including nutritional education and support within a primary prevention framework (Lichtenstein, 2006). Of particular interest also is quality of life (QoL), as it is known that cardiac disease is associated with reduced QoL (Jette & Downing, 1994) and that individuals who participate in traditional cardiac rehabilitation programmes have improved QoL (Hevey et al., 2003). Specific CVD risk factors such as hypertension and high cholesterol are also related to reduced QoL (Kannan, Thompson, & Bolge, 2008).

Traditional exercise-focused CVD programmes are based on a medical model of service provision, usually located within an inpatient setting and having a rehabilitative emphasis. These types of programmes have not incorporated a Māori worldview, have limited Māori access and participation, and do not service primary prevention. Kaupapa Māori research approaches have been utilised in community CVD projects which support the use of a Māori worldview within public service programmes (Peiris et al., 2008; Pitama et al., 2011). In addition, in New Zealand, Toi Tangata (an agency that aims to inform, educate, and advocate about wellness for Māori at government level) advise the Ministry of Health regarding Māori approaches to nutrition and physical activity and have encouraged particular kaupapa Māori–based approaches to heart health, thereby addressing some of the issues around medical modelling of service. The Heart Guide Aotearoa (Eadie & Tane, 2010) programme and the associated “Heart Coaches” have provided a Māori-centred approach, with a home-based cardiac rehabilitation programme that suits the Māori worldview more closely than other primary and secondary services. However, the Heart Guide Aotearoa is a defined rehabilitation programme following a cardiac event and therefore does not service a population with CVD who have not had a cardiac event.

Using a kaupapa Māori research methodology, this project pilots an approach whereby an intervention programme for Māori is created within an “interface space” (Durie, 2004). The interface space recognises both Māori ways of being and the Western medical model, taking aspects of both to produce an intervention that has the best of both worlds. An overarching kaupapa Māori process ensures that Māori are involved in all aspects of the project, including planning the methodological approach, critiquing the way that findings are presented, and guiding dissemination.

The overall purpose of the project was to pilot a kaupapa Māori approach aimed at reducing the risk of a first cardiac event by reducing factors that contribute to that risk. The specific aim of the pilot project was to determine the effectiveness of a 12-week exercise and lifestyle management programme, embedded within a kaupapa Maori philosophy, in relation to parameters of CVD risk and quality of life. The results relevant in the Western medical world are reported here.

Methods

The kaupapa Māori methods are explained briefly here; in-depth description can be found elsewhere (Rolleston, Doughty, & Poppe, 2016). The methods and findings in this paper conform to a Western medical and academic reporting framework.
Twelve participants were recruited from a kaupapa Māori healthcare service and by word of mouth. Inclusion criteria were Māori with more than two CVD risk factors (New Zealand Guidelines Group, 2012) and no previous cardiac event history. Exclusion criteria were previous myocardial infarction, previous stroke, unstable angina pectoris, hypertrophic cardiomyopathy, decompensated heart failure, symptomatic aortic stenosis, and severe pulmonary hypertension (Balady et al., 1998).

Participants were informed about the project both orally and in writing and had the opportunity to bring whānau (family) to an initial meeting so that the research could be explained fully. It was at this meeting that participants and their whānau were able to build the programme structure and embed Māori values and philosophies. The “interface space” ideal allows for clinical outcomes while still using a kaupapa Māori overarching approach. All processes were agreed upon by participants prior to commencement.

Participants attended an exercise physiology facility for a pre-programme assessment. The assessment included measurements of body weight, waist circumference, hip circumference, forced vital capacity (FVC), forced expiratory volume in one second (FEV1; Cardinal Health Micro-Gold standard), resting blood pressure (average of three measurements over 5 minutes), fasting total cholesterol (TC), and HDL cholesterol (CardioChek PA). The point-of-care CardioChek PA system has good accuracy compared to clinical diagnostic laboratory methods and has reasonable compliance for coefficients of variation and bias measurements (Panz, Raal, Paiker, Immelman, & Miles, 2005). Body mass index (BMI), waist to hip ratio, total to HDL cholesterol ratio, and rate pressure product (RPP) were calculated.

A quality of life (QoL) questionnaire was administered. The questionnaire was designed specifically for use in this study because during the consultation phase, participants did not think the two validated questionnaires suggested adequately measured QoL from their worldview. The questionnaire was developed using the validated tools SF-36 (Turner-Bowker, Bartley, & Ware, 2002) and WHOQOL. Spirituality, Religiousness and Personal Beliefs (WHOQOL-SRPB Group & Skevington, 2006) as guidelines and was written in plain, New Zealand English. It contained 10 questions under each of the following sections: (a) physical, (b) mental and emotional, (c) stress, (d) life enjoyment, and (e) overall quality of life. The questionnaire is non-validated by Western medical standards.

In addition, participants performed a graded exercise ECG test (GXT) on a treadmill using XScrive ECG system (Mortara Instrument Inc.) and the modified Naughton treadmill protocol (American College of Sports Medicine, 2014; Starling, Crawford, & O’Rourke, 1982). Blood pressure, heart rate, and rating of perceived exertion were recorded in the final 30 seconds of each stage. Findings from the GXT were used to prescribe the first day of exercise for each participant.

Participants were prescribed an exercise programme specific to their needs but attended the clinic as a group, three times per week over a 12-week period. Exercise sessions were monitored and supervised. Exercise prescription conformed to the American College of Sports Medicine guidelines for cardiac populations and was dependent on the initial fitness level,
cardiac risk profile, and mobility of participants (American College of Sports Medicine, 2014). Participants performed a progressive aerobic-only programme for the first 6 weeks and then commenced a combined aerobic and resistance training programme from weeks 7 through 12. Blood pressure, oxygen saturation (Edan H100B), and heart rate (Polar FT2) were measured before aerobic exercise, midway through exercise, and 5 minutes after exercise. During weeks 1 through 6 participants performed aerobic-only exercise on two different pieces of exercise equipment and measurements were recorded on both apparatus. In addition, during exercise, participants were asked for their rating of perceived exertion (Borg, 1982).

At week 6 participants provided either a written or oral 3-day diet recall. Those who gave oral accounts did so in an interview-type manner, with a member of the research team, who asked for clarification on various aspects of their diet such as quantities of food consumed, brands of products, timing of meals, and cooking methods. Written accounts were also subject to clarification questions and additional information was added to the original written account. Formal nutritional analysis of diet recalls with appropriate software was not performed. Recommendations given were based on an informal, visual assessment of the information by the lead researcher. Common recommendations were to increase vegetable and fruit intake, reduce refined carbohydrates, increase water, and swap energy-dense foods (pies, bakery foods etc.) for less dense, more nutritious choices.

Lifestyle change education was provided at agreed intervals throughout the 12-week programme. Participants decided on the areas of education that they wanted in the programme, when education sessions would be held, the venues for the sessions, and who would attend. For example, a cooking demonstration was agreed upon and facilitated by a local health provider who worked with cooks at a local marae (traditional complex for meeting and cultural purposes); it took place in the kitchen of a local Māori nursing service. Interestingly, when participants were offered education about Māori-specific topics like rongoa Māori (Māori medicines) and Māori models of health, the group declined the offer and instead chose topics typically covered in the usual 12-week care programme. The education sessions were nutrition with a cooking demonstration, yoga for stress management, practical breathing mechanics, exercise for health (classroom based), and stress management.

On completion of the 12-week programme, participants underwent a post-programme assessment identical to the pre-programme assessment described above, performed at the same time of the day and under the same medication conditions. In addition, an informal gathering with participants was held after the completion of the programme, and a semistructured focus group analysis of the 12-week programme was performed, directed by the participants. Findings from the semistructured analysis are not reported here.

Figure 1 illustrates the difference in structure between the usual care and kaupapa Māori 12-week programmes for interest only, as this was not a controlled trial comparing these programmes.
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(a) Usual 12-Week Care Programme

12-Week Programme
Participants attend as individuals
- 3 days each week
- 6 standard education sessions
- Basic nutrition analysis

(b) Kaupapa Māori 12-Week Programme

Consultation
Shared planning of programme structure
Participants and whānau involved
Critique of tools and assessments

12-Week Programme
Participants attend as a group
- 3 days each week
- 6 participant-specified education sessions
- Basic nutrition analysis with whānau-appropriate recommendations
- Whānau able to attend exercise and education sessions
- Fortnightly informal meeting

Focus Group
Plan for maintaining changes and engaging other whānau

Figure 1. The usual care programme (a) is based on a Western medical structure. The kaupapa Māori 12-week programme (b) is the product of consultation with Māori stakeholders and participants.

Statistical Analysis
The difference in individual participant measurements before and after the 12-week programme was assessed using paired Student t tests. The relationship between statin use and cholesterol, and between systolic blood pressure (SBP) and use of blood pressure medication, was assessed using unpaired Student t tests. The Shapiro-Wilk test confirmed t tests were suitable for these data. Analyses were performed using R statistical software v3.0.0 and statistical significance declared when α ≤ 0.05.

Results
Twelve participants started the programme and nine completed (six male, three female). Two participants were commuting together into the clinic and when one stopped attending due to
childcare issues, the other found it difficult to get up in the mornings when she didn’t have someone she was expected to meet, and dropped out as well. The third participant dropped out midway through the programme when an alteration in her working hours made it difficult for her to attend with the other participants and she was reluctant to come outside of that time, despite the option being available to her.

The mean age of participants was 51.5 (SD 12.4) years. Participants were not involved in regular physical activity or structured exercise prior to enrolment in the study and had not undertaken any measures to modify their lifestyle to manage their cardiac risk factors. One participant was not taking any prescription medication upon enrolment in the study. All other participants were taking at least two prescription medications. Medication type and dose remained constant over the 12-week period. Seven out of nine participants were taking at least one blood pressure medication (beta blocker, ACE inhibitor, or diuretic), four out of nine participants were taking an anticoagulant, and three out of nine participants were taking a statin for lipid-lowering therapy. In addition four out of nine participants were taking diabetes medication for glucose management. All participants had been taking their prescribed medication for at least 3 months prior to enrolment in the 12-week programme. Statin use did not affect the change in cholesterol over the 12-week programme (total cholesterol, \( p = .36 \); TC:HDL-C, \( p = .30 \)); however, no reduction in blood pressure was observed in the two people that were not taking a blood pressure medication.

Table 1 presents the pre- and post-programme results. There was a 3.1 kg reduction in weight, although this difference did not reach statistical significance. There was a statistically significant reduction in both waist and hip circumference. On average, there was a significant reduction in SBP that was reflected in a significant reduction in resting RPP. HDL-C significantly increased during the programme, and there was a nearly significant trend toward a reduction in total to HDL cholesterol ratio. There was no significant change in lung capacity as measured by FVC and FEV\(_1\).
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Table 1
Physical Results Before and After 12-Week Programme

<table>
<thead>
<tr>
<th></th>
<th>Pre-12-week programme</th>
<th>Post-12-week programme</th>
<th>Mean difference</th>
<th>p</th>
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<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td></td>
<td>[95% CI]</td>
<td></td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>122.3 ± 37.1</td>
<td>119.1 ± 30.6</td>
<td>−3.1 [−7.7, 1.5]</td>
<td>.16</td>
</tr>
<tr>
<td>Waist (cm)</td>
<td>116.7 ± 20.8</td>
<td>113.0 ± 18.9</td>
<td>−3.7 [−7.3, −0.1]</td>
<td>.05*</td>
</tr>
<tr>
<td>Hip (cm)</td>
<td>131.2 ± 20.4</td>
<td>126.6 ± 18.1</td>
<td>−4.6 [−8.8, −0.5]</td>
<td>.03*</td>
</tr>
<tr>
<td>Waist:hip ratio</td>
<td>0.88 ± 0.07</td>
<td>0.89 ± 0.07</td>
<td>0.003 [−0.03, 0.03]</td>
<td>.80</td>
</tr>
<tr>
<td>SBP (mm Hg)</td>
<td>151 ± 16</td>
<td>130 ± 19</td>
<td>−22 [−37, −6]</td>
<td>.01*</td>
</tr>
<tr>
<td>DBP (mm Hg)</td>
<td>94 ± 7</td>
<td>93 ± 8</td>
<td>−1 [−7, 5]</td>
<td>.73</td>
</tr>
<tr>
<td>RPP</td>
<td>11061 ± 1806</td>
<td>9628 ± 2091</td>
<td>−2238 [−3903, −573]</td>
<td>.01*</td>
</tr>
<tr>
<td>Total cholesterol (mmol/L)</td>
<td>4.41 ± 0.94</td>
<td>4.16 ± 0.79</td>
<td>−0.25 [−0.82, 0.31]</td>
<td>.33</td>
</tr>
<tr>
<td>HDL-C (mmol/L)</td>
<td>0.88 ± 0.28</td>
<td>1.11 ± 0.40</td>
<td>0.22 [0.06, 0.38]</td>
<td>.01*</td>
</tr>
<tr>
<td>Total:HDL ratio</td>
<td>5.34 ± 1.70</td>
<td>4.31 ± 1.77</td>
<td>−1.02 [−2.06, 0.03]</td>
<td>.06</td>
</tr>
<tr>
<td>FVC (L)</td>
<td>3.31 ± 1.22</td>
<td>3.50 ± 1.20</td>
<td>0.16 [−0.40, 0.37]</td>
<td>.10</td>
</tr>
<tr>
<td>FEV1 (L)</td>
<td>2.57 ± 0.93</td>
<td>2.68 ± 0.89</td>
<td>0.11 [−0.07, 0.29]</td>
<td>.18</td>
</tr>
</tbody>
</table>

Note. SBP = systolic blood pressure, DBP = diastolic blood pressure, RPP = rate pressure product, HDL-C = high-density lipoprotein cholesterol, FVC = forced vital capacity, FEV1 = forced expiratory volume in 1 second

QoL findings are presented in Table 2. Overall QoL improved as a result of participation in the 12-week programme. This change appears dominated by the physical component. The other areas tested were not significantly different before and after the 12-week period. Interestingly, one participant had a reduced QoL score at post-programme testing. The participant had quit cigarette smoking 3 weeks prior to the end of the study and was having substantial issues with maintaining his smoke-free lifestyle.
Table 2
Quality of Life (QoL) Results Before and After 12-Week Programme

<table>
<thead>
<tr>
<th></th>
<th>Pre-12-week programme</th>
<th>Post-12-week programme</th>
<th>Mean difference</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD</td>
<td>[95% CI]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>24.4 ± 4.5</td>
<td>27.4 ± 4.8</td>
<td>3.00 [0.07, 5.93]</td>
<td>.05*</td>
</tr>
<tr>
<td>Mental and emotional</td>
<td>25.1 ± 3.2</td>
<td>26.2 ± 3.7</td>
<td>1.11 [–1.93, 4.15]</td>
<td>.42</td>
</tr>
<tr>
<td>Stress</td>
<td>26.9 ± 4.6</td>
<td>28.3 ± 4.6</td>
<td>–1.40 [–1.05, 3.94]</td>
<td>.22</td>
</tr>
<tr>
<td>Life enjoyment</td>
<td>31.0 ± 4.5</td>
<td>32.2 ± 3.3</td>
<td>1.22 [–1.6, 4.07]</td>
<td>.35</td>
</tr>
<tr>
<td>Overall QoL</td>
<td>37.8 ± 4.6</td>
<td>41.4 ± 4.0</td>
<td>3.67 [0.54, 6.79]</td>
<td>.03*</td>
</tr>
</tbody>
</table>

* Statistically significant difference between pre- and post-12-week programme

Limitations

Limitations were inherent in this pilot. Sample size was small, and although statistically significant improvements in several CVD risk factors were demonstrated, the true magnitude of the benefit remains uncertain and needs to be examined further in a larger study.

Physical activity level prior to and during a follow-up period after the 12-week programme was not measured. Physical activity measurements, or an objective measure of cardiorespiratory fitness, in a subsequent study would be helpful in determining improvement in activity levels as a result of participation in the programme and also sustainability of activity levels after completion, both in the short and long term. In addition, nutritional aspects of lifestyle management were not measured and a dietary analysis before and after the 12-week programme would provide information about the value of the nutrition education provided. The structure and content of the QoL questionnaire resulted from the Māori consultation process, and as such the final questionnaire used was not validated as defined by Western science. However, part of the overall purpose of the pilot programme was to consider new assessments appropriate for Māori research. Further validation will be undertaken with the questionnaire in a subsequent study.

The design of the programme content and the ability of Māori within the consultation process to manage and modify the design implies that a subsequent study based on the same philosophy will have some differences compared to this pilot. A project embedded within a kaupapa Māori philosophy that has produced findings that are significant for Māori health has never been retested with a new group of Māori participants to determine if similar findings occur with alterations in methods. A project with a larger sample is therefore currently in trial phase (NZHF Grant #1648). A larger sample will mean more participants involved in the consultation process, and there are likely to be methodological challenges associated with the expectation that the group function as a collective. The subsequent study is therefore essential for extending our
knowledge about whether a successful programme that has integrated Maori and clinical worldviews, in a small population, can be extended to a wider population.

Discussion

This pilot project using Durie’s (2004) “interface space,” ideal within a 12-week exercise and lifestyle management programme, was successful in improving a number of important parameters of CVD risk. SBP, waist and hip circumference, and HDL cholesterol were significantly improved by the intervention with a trend for a reduction in total to HDL cholesterol ratio. In addition, physical and overall quality of life improved.

Reducing the risk of a first cardiac event is achieved by a modification in parameters that contribute to that risk. Hypertension affects at least one in four adults worldwide (Kearney et al., 2005), and there is a continuous and logarithmic relationship between hypertension and cardiovascular disease risk (Ezzati, Lopez, Rodgers, Vander Hoorn, & Murray, 2002). A reduction in SBP therefore contributes to a reduced risk of CVD and a first cardiac event. SBP was markedly reduced for participants in this pilot study. A low HDL cholesterol level is an established and independent predictive risk factor for CVD, supported by a variety of evidence from epidemiological studies (Assman, Cullen, & Schulte, 2002; Cziraky, Watson, & Talbert, 2008). HDL increased over the 12-week intervention period from an average that was below the recommended level of > 1.0 mmol/L to within the recommended range for reducing CVD risk (0.88 ± 0.28 mmol/L pre-programme to 1.11 ± 0.40 mmol/L post-programme). Previous research has demonstrated that waist circumference effectively identifies individuals at risk of CVD across different BMI categories (Janssen, 2002). Waist circumference fell by an average of 3.7 cm over the 12-week intervention period. Despite the average waist circumference still being above the recommended circumference for both men and women after the intervention period, any improvement is positive in terms of risk reduction (Janssen, Katzmarzyk, & Ross, 2002). When a 3.7 cm reduction in waist circumference is combined with a reduction in SBP and an increase in HDL cholesterol, the overall outcome is a reduced risk of disease and cardiac events.

Lack of physical activity is a CVD risk factor (American College of Sports Medicine, 2014). Physical activity level was not determined prior to participants’ enrolment in the 12-week programme, and therefore a comparison of activity level before and after the 12-week intervention cannot be made. However, participants were not involved in structured exercise prior to the study and anecdotally were not active upon enrolment. An assumption can therefore be made that the programme was able to modify a fourth factor contributing to CVD risk—physical inactivity. Anecdotal reports indicated that participants found the first few weeks of exercise difficult but enjoyed the regular sessions once they had “created a habit.”

QoL is integral in wellness research, and measuring QoL fits well with the holistic Māori model of health. Poor QoL is linked to issues of mental health, and subsequently poor mental health is linked to long-term conditions such as CVD and diabetes (Katon, Lin, Russo, & Unützer, 2003; Kilbourne et al., 2009). It is also known that individuals with cardiac disease
report poor QoL (Jette & Downing, 1994). The relationship between improved QoL and improvement in measures of CVD risk is not well established. However, with a holistic view of health in mind, the improvement in both physical and overall QoL in this project is a positive finding and contributes to the overall strength of the programme for a Māori population. The participants were given the ability to structure the programme to suit their worldview, and they made a collective decision not to use either the SF-36 or the WHOQOL-SRPB tool to measure QoL because they felt neither reflected that worldview. The QoL questionnaire developed in collaboration with Māori stakeholders, participants, and their whānau was a novel process for the research team but provided tino rangatiratanga (the ability to self-determine) for Māori, within a society driven by Western perspectives.

Having influence over the process of health gives people ownership and builds trust where previously there may have been disempowerment and a perceived paternalistic relationship between health provider and patient. Choosing the content and mode of delivery of education sessions also provided participants with the ability to self-determine. In this way, participants identified what was important to them to learn about health instead of a standard programme delivery of set education determined by the health provider. Exercise programmes were tailored to the individual, but participants attended exercise sessions as a group. The whānau collective has been identified as a fundamental component of a Māori worldview and attending exercise as a collective, despite individual exercise prescriptions, is an illustration of how the interface between science and mātauranga Māori (Māori knowledge and wisdom) works in practice.

The information gained in this project serves the Western ideals of science and knowledge but also allows for a Māori worldview and does much to alleviate the mistrust felt by Māori of historical research that has privileged Western science and knowledge.

The purpose of this pilot was to use an interface space concept to integrate a Māori worldview with clinical components to modify CVD risk in a population that is disproportionately represented in CVD morbidity and mortality statistics. Interestingly, giving the participants control over the content and structure of the programme did not produce a 12-week iteration that was too dissimilar to the usual care condition (Figure 1). It is therefore perhaps the acknowledgement of culture that is fundamental in this process and the ability to self-determine health and feel as if there is partnership with a healthcare service.

**Conclusion**

A 12-week exercise and lifestyle management programme, embedded within a Māori philosophy, is a low-cost intervention that is capable of changing a number of CVD risk parameters: SBP, waist circumference, HDL, and physical activity in this instance. An intervention that can modify a number of cardiac risk parameters over a period of weeks could be a better way of managing CVD risk than modification of parameters one at a time. A study with a larger sample would be required to make concrete recommendations and also to assess
adherence, which was relatively easy with a small cohesive group but may be more difficult with a larger number of participants. Long-term maintenance of lifestyle management also needs to be assessed in a comprehensive manner to ensure positive changes are not reversed.

References


The Effect of a 12-Week Exercise and Lifestyle Management Programme on Cardiac Risk Reduction: A Pilot Using a Kaupapa Māori Philosophy • Anna Rolleston, Robert N. Doughty, Katrina Poppe • DOI:10.18357/ijih121201716905


